MASTER OR ARTS THESIS

OF

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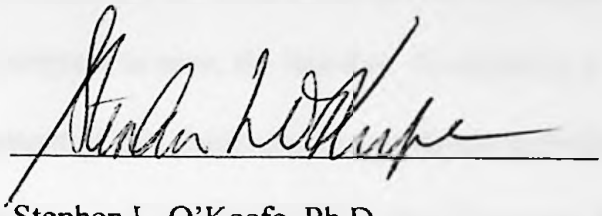
Major Professor: 

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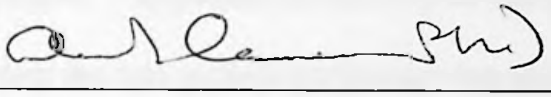

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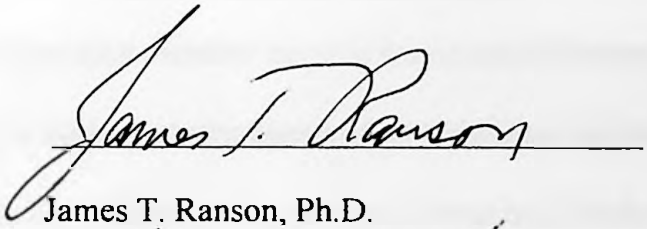

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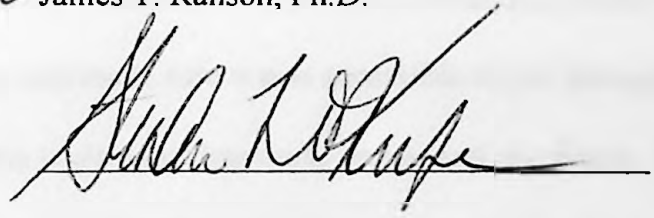

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I cannot express what my family's support, encouragement, and patience has meant to me over, not only the past few years, but a lifetime. My parents, David and Shirley Evans, made my education a priority and made sure it was accessible to me throughout the years. I only hope they realize the impact this has made on me and my future. Lastly, I would like to thank my friends and coworkers for the support, encouragement, and understanding that they have given me throughout the completion of this program.

As John Donne, a seventeenth-century English author said in a sermon, "No man is an island." This is interpreted as no one is self-sufficient; everyone relies on others, just as I, too, have relied on all those individuals who have played a part in my life.

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Seniors' Knowledge of Elder Abuse, Neglect, and Exploitation in Urban Versus Rural West Virginia

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Abstract

Elder abuse, elder neglect/elder self-neglect, and elder exploitation, often referred to as elder maltreatment, is a present reality in the world today. Available research is limited since this topic has been formally recognized only since 1970. To date, limited progress has been made in understanding what elder maltreatment entails and its scope. The purpose of the present study was to test the knowledge of urban and rural West Virginia senior citizens (ages 55 and above) on the given topic. One-hundred and nine senior citizens from four senior citizen centers in WV (two urban and two rural) were included in this study. These senior citizens completed a packet consisting of a Letter of Consent sheet, an Informational Data sheet, a Questionnaire sheet, and five different Case Sample sheets. A score was derived from the packet for each participant. Analyzing the data by employing the 3x2 Chi-Square statistic for each of three hypotheses, it was found that all three were significant. Thus, results were as follows: 1)Higher knowledge levels exist in urban versus rural WV counties on the given topic, 2) A higher level of social activity correlates with a higher level of knowledge on the topic, and 3) willingness to report on family member perpetrators of elder maltreatment is greater from those participants with a higher knowledge level on the topic than those participants with a lower knowledge level on the topic. In summation, the present study found that a need for information, regarding elder maltreatment, is greatest among the rural population and those individuals with few social contacts.

Seniors' Knowledge of Elder Abuse, Neglect, and Exploitation in Urban Versus Rural West Virginia

Elder abuse, elder neglect/elder self-neglect, and elder exploitation (often referred to as elder maltreatment for brevity purposes) was formally recognized as recent as 1970 (Johnson, 1995). Although maltreatment of the most vulnerable members of a society has always existed, only within the past two to three decades has the social phenomenon of elder maltreatment been brought into public awareness to any degree worthy of notation (Goldstein, 1995).

There are many explanations for this virtually deafening silence regarding elder maltreatment. Until the recent past, elder maltreatment was covered with a veil of secrecy mostly due to the notion of the binding family bond. In 1970, the first references to "granny bashing" were published in British literature (Frazier, 1994). Since these references, interest in this topic has grown slightly over the years and more so at the present time; however, maltreatment remains a new issue (Johnson, 1995). Thus, research on this topic is in its infancy. In fact, Bennett and Vernon (1995) stated that, due to research being in its infancy, it is not possible to accurately quantify the extent of the problem.

Data known about this social phenomenon indicates it occurs among all racial, ethnic, and economic groups. It is of no regard to occurrence whether the elder victim is healthy or unhealthy, nor does it make a difference if the elder victim is male or female. In addition, it is also known that on average, a state spends $22 per child for youth protection, but less than $3 per elder for elder protection, despite that forty percent of reported maltreatment involves the elder population ("American Medical," 1996).

Hence, it is abundantly obvious that the two to three million American elderly (every one in three), who are maltreated each year, do not elicit the concern that is elicited by a poorly cared for and/or bruised child (Gilman, 1993). Perhaps this is due to that, as a society, we tend to stereotype symptoms of elder maltreatment, such as senility, bruises, etc., as normal signs of aging instead of assessing each particular individual case.

In order to be able to fully comprehend the scope of elder maltreatment at the present time, statistics are available for reference purposes. To begin, in 1994, one in eight persons were elderly ("United States," 1995). Regarding this elderly population of 65 years and older, the estimated prevalence rate of maltreatment in the United States has ranged from four to ten percent (Wolf, 1996). Elder maltreatment is estimated to affect one in three elders (Bernstein, Silver, and Aging, 1997). Goldstein (1995) stated that 2.5 million cases or more are estimated for occurring in domestic/noninstitutional settings each year. Expectedly, there is anticipated to be a steady rise in the number of elder maltreatment cases as the elder population itself increases in number ("American Medical," 1996). According to the United States Census Bureau's "middle-series" projections, by the year 2050, the elderly population will more than double in number, reaching 80 million. The growth will occur during the years 2010 and 2030 due to the baby boom generation entering their elderly years ("United States," 1995).

A hindrance to obtaining solid research on elder abuse is that each state may operate under its own definitions as to what constitutes elder abuse and all which it encompasses. Due to the latter, acts which may be considered elder abuse in one state may not in a

different state. In addition, along with varied definitions, the age at which a person is considered an elder may vary between states and agencies, as well. However, on a federal level, definitions for elder abuse, neglect, and exploitation were established and included in the 1987 Amendments to the Older Americans Act as guidelines to aid in identifying the problem (Byers and Zeller, 1995).

For the purpose of this study, definitions for West Virginia (WV) are made available by the WV Commission on Aging. In WV, elder abuse is defined as " willful infliction, physical pain, injury, unreasonable confinement, and/or intimidation [of an incapacitated] elder." Neglect is defined as "deprivation of essential services [of an incapacitated] elder." There is not a separate definition for exploitation in the state, but, an exploitation component is included in the definition of neglect. An incapacitated adult/elder is any person who, due to physical, mental, or other infirmity, is unable to independently perform the daily activities of life which are necessary to sustaining life and reasonable health ("Definitions," 1997)

Known warning signs and risk factors, along with profiles of prototypal perpetrators, are available which are characteristic of elder maltreatment, regardless of the definition employed. For the reason that elder maltreatment may occur in differed settings, such as institutional settings and noninstitutional settings, shared and distinct signs and factors are available for each setting. Shared warning signs for elder physical abuse include the presence of multiple bruises, multiple injuries in various stages of healing, burns, fractured or broken bones, friction/rope marks, excessive amounts of cuts or scrapes, and

effects of deliberate overmedication. Shared warning signs for elder neglect include skin rashes and the like, malnutrition, dehydration, untreated illnesses or injuries, absence of necessary medication, and frequent visits to the hospital for unaccounted for or vague injuries or illnesses. The perpetrator of neglect prevalently threatens, intimidates, and isolates his or her victim (Anonymous "Warning," 1996). In addition to these warning signs, Bond (1986) has come to suspect that when an elder is physically abused, that same elder is also being emotionally, financially, and medically abused.

Concerning risk factors, Wolf (1996) provides a comprehensive list which is characteristic of elder maltreatment. The first risk factor exists when a perpetrator possesses an unhealthy dependency on the elder victim, or more rarely, vice-versa. The second risk factor is if the perpetrator is in a disturbed, psychological state. The third risk factor exists when the elderly victim either is frail or viewed as frail and/or disabled. The fourth risk factor deals with the isolation of the elderly victim from others outside of the caregiving environment. The final risk factor which is noted is when alcohol/substance use or abuse occurs on the part of the perpetrator.

The elderly, as victims, not only suffer from the effects of actual maltreatment, they also suffer from the fear itself of maltreatment. A study conducted in a noninstitutional setting in the Metropolitan Boston area, involving 2,000 elders, found that 3.2% of the elders had experienced physical abuse and/or neglect since turning 65 years of age. This same study, with the addition of a financial abuse category, was conducted in Canada.

The Canada study found that financial abuse was the most prevalent form of abuse (Wolf, 1996). Another study, employing written questionnaires and clinical evaluations, was conducted in a small semi-industrialized town in Finland. The results of the study were discussed in terms of gender. A prevalence rate of abuse for men was found to be 2.5% and the rate for women was found to be 7.0%. The prevalence rate for both sexes was found to be 5.4% (Wolf, 1996).

A study conducted in a noninstitutional setting in Alabama surveyed fifty elders, those adults being 62 years and above, and their primary caregivers. An area surveyed questioned where one thought elder abuse was most likely to occur. Elders responded that the maltreatment was most likely to occur in a nursing home (45.9%), while the caregivers gave the response of the elder's home (41.6%). The results of a second area surveyed showed that when questioned about the most appropriate context for dealing with elder maltreatment, elders responded by stating that the most appropriate context is the family and/or social service agencies, while the caregivers responded, to a greatly more significant degree, by identifying the court system as the best context (Johnson, 1995).

All studies covered clearly are a good beginning for a body of research on elder maltreatment. However, because this is a relatively new topic, limited amounts of further research studies exist at this time.

Elder maltreatment, as one may have imagined, is often hard to detect. Though hard to detect at times, it is not impossible A few screening devices are available to qualified individuals, such as doctors and social service agency workers, to aid in the detection of elder maltreatment. These devices range from very brief screeners to more elaborate, thus lengthier devices. A couple examples are The Qualcare Scale developed by Phillips, Morrison, and Young in 1990 and The Brief Abuse Screener (BASE) developed by Reis and colleagues in 1993. The Qualcare Scale's main purpose is to show whether the caregiver fulfills the needs of the elder. Thorough examinations of this scale have proven it to be valid and reliable (Archambault, Bravo, Duboise, Girouard, and Gosselin, 1995). The BASE was designed for screening specific types of abuse and the need for immediate treatment or intervention. Reliability and validity studies for this instrument have shown to be at or above acceptable levels (Nahmiash and Reis, 1995). While these and other similar assessment tools are helpful, the most important tools available are the assessment via the interview and the clinical evaluation.

If elder maltreatment is suspected, many agencies (e.g., Adult Protective Services) and hotlines (e.g., The National Eldercare Locator Hotline) are available for accepting elder maltreatment reports. Consequently though, elders are unlikely to report maltreatment due to the fear of retaliation, not being believed, shame, or various other reasons. In fact, more often than not, even if an elder were to wish to file a report, he/she would be unsure of the appropriate place(s) to do so. Since most elders do not report,

approximately 70% or more of reported cases of elder maltreatment are from third-party observers (Berliner, 1997).

As of 1995, mandatory reporting laws have been enforced in 42 states. Only the following states possess voluntary reporting: Colorado, Illinois, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin. All states are subject to differ on what information is requested/required at the time of filing the report (Goldstein, 1995). Despite these laws being in place, the public's awareness of them may be lacking. It is estimated that, due to various reasons, up to 80% of elder maltreatment cases are left unreported (Anderson, Mittelmark, Rohrer, Schiferaw, Walls, and Wofford, 1994).

Specifically in WV, the mandatory reporting law encompasses all medical, dental, mental health professionals, Christian Science Practitioners, religious healers, social workers, peace officers, and law enforcement officers. All reports are to be filed with the local Department of Human Services. Failure to make a report may result in a fine of up to $100 and/or imprisonment of up to ten days in the county jail ("West Virginia," 1997).

After a report is filed, if when investigated, charges are substantiated, prevention and intervention systems are available. One example of such a program is the TRIAD Programs which are already established in many areas. This program entails sheriffs, police chiefs, and members of senior organizations to work together to fight crime (such as elder maltreatment) against elders. A second example is banks which are presently

establishing tougher measures in order to help prevent elder exploitation from occurring as easily. A third example, especially for the intervention aspect, are multidisciplinary teams. However, at present, it is not uncommon for prevention/intervention strategies to be uncoordinated.

Wolf (1996) states that all fifty states possess some type of legislation which enables them to protect and provide services to vulnerable adults, such as elders. One law is covered in the 1987 Amendments to the Older Americans Act separate provision titled Elder Abuse Prevention Activities, Title III, part G. Through this law, states are required to develop and provide public education on identifying abuse, neglect, and/or exploitation. Beyond this education, procedures must be available and made public to individuals and agencies on how an elder maltreatment form is filed, accepted, and investigated (Goodrich, Hwalek, and Quinn, 1996). Other laws and acts exist but, like definitions of elder maltreatment, these also tend to vary from state to state.

Elder maltreatment is a present reality. To date, limited progress has been made in understanding what elder maltreatment entails and its scope. While the true scale of elder maltreatment remains an unknown at this current time, it is not feasible to treat this "horrific epidemic" as a minority problem.

Purpose of Study

The main purpose of the present study is to test the knowledge of urban and rural West Virginia (WV) senior citizens on the topic of elder abuse, elder neglect/elder self-neglect, and elder exploitation. Urban being defined as "designating or of an

incorporated or unincorporated place with at least 50,000 inhabitants" by the United States' Census Bureau. The same source being referred to, rural is defined as "of or characteristic of the country, country life, or country people; rustic, having to do with farming and agriculture, living in the country." For the purpose of this study the definitions provided by the WV Commission on Aging regarding elder maltreatment, referred to previously, were utilized. The operational definition utilized in this study for senior citizen, since there exists no "magic" age at this time, is an individual who is 55 years of age or older.

Hypotheses

1. Higher knowledge levels, regarding elder abuse, elder neglect/elder self-neglect, and elder exploitation, exist in urban counties versus rural counties in West Virginia.
2. Higher level of social activity correlates with a higher level of knowledge on the topic of elder maltreatment.
3. Willingness to report on family member perpetrators of elder maltreatment is greater from participants with a higher knowledge level versus a lower knowledge level of elder maltreatment.

Method

Subjects

Participants in this study were selected on a random, voluntary basis at four senior citizen centers. Two of the centers were in urban counties -- Kanawha (population of

206,195) (29 participants) and Cabell (population of 96,837) (30 participants). The remaining two centers utilized were located in rural counties -- Roane (population of 15, 389) (27 participants) and Boone (population of 26,291) (25 participants). A total of 111 senior citizens participated in the study. Two test forms were found to be incomplete therefore 109 participants were included in the study, with 47 of them being male and 62 being female. Ages of these senior citizen participants ranged from 58 to 92 years of age.

Procedure

A "Letter of Agreement" form was signed and dated by the facility administrator or other authorized individual at each of the four senior citizen centers. In addition, "Consent to Participate" forms were given to each senior citizen involved in order for it to be signed and dated. These forms were collected immediately. An "Informational Data" sheet, a "Questionnaire" sheet, and five different "Case Sample" sheets were distributed to the participants as a packet (see Appendix B). The participants were briefed as to the main purpose of the study along with instructions given on the proper completion of the packet. Aid was given, if requested, in the form of reading the packet aloud to the individual and/or writing in the individual's responses on the packet materials. Anonymity and confidentiality were ensured to each of the participants.

Regarding the instruments utilized (the packet) the source of data for the Case Samples is The Department of Health and Human Services' Adult Protective Services (APS) unit located in Dunbar, WV. The samples were derived from actual APS past

cases and/or cases that APS would not accept as elder maltreatment. A supervisor at APS provided approximately twenty sample cases. Of those provided, elder maltreatment was present in some of the samples, and elder maltreatment was not present in the remaining samples. Five of these samples were chosen by the researcher based upon designated criteria. Regarding this criteria, cases were chosen by being concise, by containing single episodes of abuse -- if abuse was present, and by being relatively devoid of extraneous and often confusing variables. The chosen samples were utilized in a pilot study. The pilot study, at the given APS center, utilizing "experts" in the form of five APS workers, was conducted in order to determine reliability and validity. The five Case Samples were tested. All answers collected were correct and corresponded with the exception of one Case Sample which was left blank on one individual's form. Hence, expert inter-judge agreement was 100% for completed forms. Hence, this instrument was shown to be reliable. In addition, all evaluators with completed forms, correctly identified the abuse cases and the non-abuse cases. The latter provides evidence of high predictive validity.

The packets from the present study were scored by using a designated key. The "Questionnaire Sheet" was scored by counting the appropriate responses. The key for the latter was 1)yes, 3)yes, 5)yes, and 7)yes, yes, yes, yes. One point was awarded to each correct response. A total of 7 points were possible on this section of the packet for hypotheses 1 and 2. Hypothesis 3 was scored in the same manner with the exception of number 7 not being scored on the "willingness to report on family" item. The latter was

excluded in order to protect internal validity for this hypothesis. Number 7 was now worth 3 points, thus making 6 the total number of points possible for the above given section. All items on the form and not included in the key are strictly for supplemental data. The "Case Samples" were scored, for all hypotheses, by assigning one point to each appropriate response and then tallying all appropriate responses. The key for the latter was 1)no, 2)yes, 3)yes, 4)no, and 5)yes. A total of 5 points were possible on this section of the packet. Thus, overall, all scores included, 12 possible points were available for hypotheses 1 and 2, and 11 possible points were available for hypothesis 3.

A rural/urban category was established as well as a category distinguishing between those who would report on family perpetrators of elder maltreatment and those who would not report on the same. The number of listed senior affiliations/senior social activities from the "Informational Data" sheet was tallied for each individual. Other information gathered on this sheet was supplemental data.

Regarding the present study, a 3x2 Chi-Square was employed on data for each of the three hypotheses. In order to complete these Chi-Square tables, three categories were set up, for hypotheses 1 and 2, by placing scores in a low category if they fell below 9, a median category if they fell at 9, and a high category if they fell above 9. These divisions were established since 39 scores fell below 9, 30 scores were equal to 9, and 40 scores fell above 9. As mentioned, the possible range for scores was 1 point -12 points for these hypotheses. Three categories were also set up for hypothesis 3 by placing scores in a low

category if they fell below 8, a median category of they fell at 8, and a high category if they fell above 8. The possible range for scores for this hypothesis was 1-11 points, thus accounting for the categorical division shifts.

Results

Based upon $^{2}(2, N = 109) = 8.17, p < .05$, hypothesis 1 was confirmed, as shown in Table 1. Urban participants do tend to be more knowledgeable, as compared to rural participants, regarding elder maltreatment.

As Table 2 shows, based upon $^{2}(2, N = 109) = 5.26, p < .05$, hypothesis 2 was confirmed. Participants with a low number of senior social activities tended to score lower on knowledge of elder maltreatment, as compared to those participants with a higher number of senior social activities.

As Table 3 shows, based upon $^{2}(2, N = 109) = 34.38, p < .05$, hypothesis 3 was confirmed. Participants with a higher knowledge level of elder maltreatment were significantly more willing to report on family perpetrators of this maltreatment than were those participants with a lower knowledge level of elder maltreatment.

Discussion

Results for hypothesis 1 showed that urban participants are more knowledgeable about elder maltreatment as compared to rural participants. Therefore, from this information, it may be concluded that educational information on elder maltreatment should be targeted at rural areas. This educational information should involve defining what constitutes elder maltreatment and the logistics of filing a report.

Table 1

Test Scores for Urban Versus Rural Participants

	Low	Median	High	Totals
Rural				
N=51	25	13	13	51
Expected Value	18.25	14.04	18.71	
Urban				
N=58	14	17	27	58
Expected Value	20.75	15.96	21.28	
Totals	39	30	40	109

Statistic	Df	Value	p
Chi-Square	2	8.17	0.05

Note. Criterion $^2 = 4.85$.

Table 2

Test Scores for Low Versus High Senior Social Activities

	Low Scores	Median Scores	High Scores	Totals
Low Senior Social Activities				
N=89	36	24	29	89
Expected Value	31.84	24.50	32.66	
High Senior Social Activities				
N=20	3	6	11	20
Expected Value	7.16	5.50	7.34	
Totals	39	30	40	109

Statistic	Df	Value	p
Chi-Square	2	5.26	0.05

Note. Criterion $^2 = 4.85$.

Table 3

Test Scores for Willingness Versus Unwillingness to Report on Family

	Low	Median	High	Totals
Unwilling to Report on Family				
N=21	16	3	2	21
Expected Value	6.94	6.36	7.71	
Willing to Report on Family				
N=88	20	30	38	88
Expected Value	29.06	26.64	32.29	
Totals	36	33	40	109

Statistic	Df	Value	p
Chi-Square	2	22.09	0.05

Note. Criterion $^2 = 4.85$.

Results for hypothesis 2 showed that more socially active participants were more knowledgeable about elder maltreatment than were rather socially inactive participants. While it might not be practical to increase social activity in order to increase knowledge and reporting, there are other implications of this finding. Educational information should be targeted at rural participants, and if possible, all socially isolated individuals. In addition, senior activities need be established in these rural areas. Activities could include garden clubs, day programs, craft clubs, and etc. Availability of transportation is often a problem in these areas and should be given consideration. Poster campaigns at local banks and supermarkets could be established as well as mail campaigns.

Results for hypothesis 3 showed that participants with a higher knowledge level of elder maltreatment were significantly more willing to report than those participants with a lower knowledge level. This data showed a very strong association between these two variables. At the low level of knowledge, an almost 50/50 split occurred for those participants willing to report on a family perpetrator of elder maltreatment and those not willing to report on the same. At the high level of knowledge, participants were nearly unanimous in their willingness to report on a family perpetrator of elder maltreatment.

In order to rule out the possibility that the variables of rural/urban and high/low senior social activities are essentially the same, a post-hoc analysis employing Fisher's Exact Test was conducted (see Table 4). Table 4 shows a breakdown of the mentioned variables according to their willingness to report on a family perpetrator of elder maltreatment.

This comparison was restricted to lower scoring participants because, of 70 participants who had a median score or higher, only two participants fell in the "unwilling to report on family" category, while lower scoring participants were evenly divided. As the table shows, based on Fisher's Exact Test, no significant relationship exists between the rural/urban or high/low senior social activities variables and willingness to report on family perpetrators of elder maltreatment. Therefore, these two variables are not simply measuring the same thing.

Conclusions

The present study demonstrated the strong need for greater outreach efforts to the elder population studied within, especially in rural areas. The results found with this sample population may be applied to the larger population of elders having similar characteristics as those in the sample population. Thus the recommendations, which ensue for this study, may also be applied to this larger population.

Programs which could be utilized in order to fulfill this need for outreach programs are as follows:

1. Training programs which would be made available to caregivers in order to help them in working with their elder relatives/nonrelatives,
2. Extended educational material on the topic of elder maltreatment presented via the radio and television,

Table 4

Relationship Between Demographic Variables and Willingness to Report on Family

	Willing to Report	Nonwilling to Report
Rural	7	7
Urban	13	12
p = 0.67		
High Senior Social Activities	2	1
Low Senior Social Activities	17	19
p = 0.48		

Statistic	p	Results
Fisher's Exact Test	0.67	Nonsignificant at .05 Level
	0.48	Nonsignificant at .05 Level

3. Greater training be made available for those professionals who work with this elder population in order for these professionals to educate their clients as well as to have to ability to screen and detect elder maltreatment, and
4. Social activity programs established and made available, including transportation, for this elderly population.

Whatever the route the educational material travels, it should focus on definitive aspects of elder maltreatment as well as practical matters such as filing an elder maltreatment report. This information is essential in improving the knowledge level of elders and thus, improving the reporting rate from these same elders.

The present study did not include nursing home elderly and/or their kin nor did it include homebound elderly. This study was limited to those elders who were physically able to attend functions at the senior citizen centers. It may be of interest to conduct further studies which consider these important subgroups among the elderly population.

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Appendix A

Review of Literature

As Americans we live in a violent society. It is not uncommon to read in a newspaper or hear on the television news, on a daily basis, a recurring theme, along with cited examples, of domestic violence -- such as child abuse, sexual abuse, or spouse abuse. However, rarely is one informed of the equally important and equally widespread social problem of elder abuse, exploitation, and /or neglect, often used interchangeably as elder maltreatment, as in this review.

There are many explanations for this virtually deafening silence regarding elder maltreatment. It was just as recent as 1970 that elder maltreatment was formally recognized (Johnson, 1995). These first references of "granny bashing" were made in British literature (Frazier, 1994). Until the references became known to the public, elder maltreatment was covered with a veil of secrecy due to the notion of the binding family bond. Though maltreatment of the most vulnerable members of a society has always existed, only within the past two to three decades has the social phenomenon of elder maltreatment been brought into public awareness to any degree worthy of notation (Goldstein, 1995). Although interest has grown in the past fifteen years or so, elder maltreatment is still considered a "new issue" on the public agenda (Johnson, 1995). Due to the latter, the problem is highly underresearched. In fact, it is stated (Bennett and Vernon, 1995) that since research is still in its infancy, it is impossible to accurately quantify the extent of the problem.

Despite limited amounts of research, it is known that elder maltreatment occurs among all racial, ethnic, and economic groups. No distinction of occurrence is made

between healthy and frail elderly nor between men and women. The maltreatment, at times deliberate and at other times unintentional, may be made by any number of persons and in any number of settings of which will be covered more thoroughly later in this review (Berliner, 1997). Shockingly, it is also known that on average, a state spends $22 per child for youth protection, but, less than $3 per elder for elder protection despite that forty percent of reported abuse involves the elder population ("American Medical," 1996).

Dr. Terry Fulmer, an associate dean for research at the Columbia University School of Nursing, was quoted by Gilman (1993) as saying, ' " If an older person has bruises on the arms or becomes confused, we do not think about elder abuse."' ' " We tend to perceive such symptoms as normal signs of aging, but they are not."' Due to this blaming black-and-blue marks on falls, and confusion on senility, the signs that should "ring a detection alarm" for elder maltreatment do not. Therefore, the two to three million American elderly who are maltreated each year do not elicit the concern that is elicited by a poorly cared for and/or bruised child (Gilman, 1993).

The elderly, as victims, are wounded several times over. They suffer from the effects of actual maltreatment in addition to the fear of maltreatment, without any sense of security or control. In order to replace this lost sense of control and security, we (as a society) must educate and become educated on elder maltreatment and all which it entails so that we can put a stop to this "horrific epidemic."

In order to fully comprehend the scope of the problem at this time, by using what data is available, statistics need to be presented for reference purposes. To begin, the population (1994) consisted of 33.2 million elderly or, viewing it in a different way, one in eight persons were elderly ("United States," 1995). Regarding this population of 65 years and older, the estimated prevalence of elder maltreatment in the United States has ranged from four to ten percent (Wolf, 1996). Thus, elder maltreatment is estimated to affect one in three elders (Bernstein, Silver, and Aging, 1997). Since caregivers are most often the abusers, it is important to realize that eighty percent of care given to the elderly is provided by family members, and the remaining twenty percent by paid caregivers and such (Archambault, Bravo, Duboise, Girouard, and Gosselin, 1995). To break the latter down even further, Goldstein (1995) stated that 2.5 million cases or more are estimated for occurring in domestic/noninstitutional settings each year. Information based on data from the United States Bureau of the Census stated that unrelated caregivers, such as in an institutional setting are responsible for one quarter of elder abuse cases ("United States," 1995). As one may have imagined, there is expected to be a steady number of increases in elder abuse cases as this targeted population increases in number ("American Medical," 1996). According to the United States Census Bureau's "middle-series" projections, between the present year and the year 2050 the elderly population will more than double itself, thus reaching eighty million. The growth will occur between the years of 2010 and 2030 due to the "baby boom" generation entering their elderly years. Within the latter time frame, a growth in the number of elderly will

consist of 2.8% annually ("United States," 1995). Though the statistics, as stated, on the given topic may overwhelm one, they are only an estimate since only one in fourteen cases of elder maltreatment is reported ("American Medical," 1996). It is estimated that up to eighty percent of the cases go unreported (Anderson, Mittelmark, Rohrer, Schiferaw, Walls, and Wofford, 1994). Nevertheless, the trend does seem to be moving to reporting. The National Center on Elder Abuse (NCEA) in 1994 found that the number of cases reported rose by 106% from 1986 to 1994. This same agency was completing the first national incidence study, based upon complete data, beginning in the 1997 summer (Littwin, 1995). However, given that a national incidence study of this sort does not exist at this time, all statistics presented need be viewed, as previously mentioned, for points of reference only.

One reason for the lack of solid prevalence data on a national level is the absence of a uniformly accepted elder maltreatment definition. At present, each state operates under its own set of definitions as to what constitutes abuse, neglect, and/or exploitation. Actions which are considered as abusive, therefore, may vary from state to state.

When defining elder maltreatment, two categories are typically brought forth. The two categories are abuse and neglect. The distinction between the two categories depends on such factors as frequency of maltreatment, intensity and severity of maltreatment, and the consequences involved (Wolf, 1996).

On a federal level, definitions for abuse, neglect, and exploitation were included for the first time in the 1987 Amendments to the Older Americans Act; they were included

as guidelines to help identify the problem. In regard to the categories mentioned above, this Act breaks them down into even smaller units. The Act sets forth definitions for domestic elder abuse, institutional elder abuse, and self-neglect/self-abuse. The definitions for the latter are as follows:

> Domestic Elder Abuse -- any of several forms of maltreatment of an elder by a person who has a special relationship with the elder, such as a friend, spouse, or child.
>
> Institutional Elder Abuse -- like domestic elder abuse but it occurs in residential facilities, such as nursing homes and board/care homes, and it occurs at the hands of a person who is typically under a contractual or legal obligation to provide care for the elder.
>
> Self-Neglect/Self-Abuse -- that behavior of an elder which threatens his or her own health and safety ("National Center," 1996). Self-neglect is the most common form of the two (Byers and Zeller, 1995).

Manifestations of elder maltreatment as defined by Wolf (1996) may be either one or a combination of four groupings. The four groupings are physical abuse, psychological abuse, financial abuse, and neglect. Wolf defines physical abuse as the infliction of physical pain or injury. The infliction may take the form of slapping, bruising, sexually mistreating, etc. Psychological abuse is defined as the infliction of mental anguish. The infliction may take the form of humiliation and/or intimidation. Financial abuse is defined as a refusal/failure to provide and fulfill a caretaking obligation. The caretaker may withhold food or other health needs, he or she may abandon the elder, etc.

All of the latter acts may be either intentional, such as due to laziness, or unintentional, such as due to the lack of knowledge.

A listing of terminology used by the State of West Virginia (WV) to define abuse, neglect, and exploitation is made available through the WV Commission on Aging. In WV, elder abuse is defined as "willful infliction, physical pain, injury, unreasonable confinement, and/or intimidation." Neglect is defined as "deprivation of essential services." There is not a separate definition for exploitation in WV, but, an exploitation component is included in the definition of neglect ("Definitions," 1997).

To show the extent of inconsistency in the various definitions, Schultz (1983) researched at what age a person is considered an elder. It was found that the Department of Welfare states the "magic" age as 65 and older, the Older Americans Act, Title III-B and III-C, states 60 years and older, while the Title V Senior Employment Program, from the same act as latter, states an elder is a person 55 years and older. As long as an inconsistency of definitions between states and agencies exist, all comparability efforts will thus be hindered.

Despite this lack of consistent definitions, there are known warning signs and risk factors that are characteristic of and for elder maltreatment. A cautionary statement must be given as to the fact that not all warning signs by themselves indicate maltreatment or self-neglect just as the "fit" of a risk factor does not have to definitely indicate abuse. When several signs are observed in combination or several risk factors are present there may be reason to be suspicious of wrong doing.

There are many warning signs for physical abuse, physical/sexual abuse, and neglect. In dealing with physical abuse, common warning signs are as follows: multiple bruises, multiple injuries in various stages of healing, burns, fractured or broken bones, friction/rope marks, excessive amounts of cuts and scrapes, and/or effects of deliberate overmedication. Signs of physical/sexual abuse, which are typically expressed through one's behavior, include the elder becoming fearful, frightened, agitated, and/or upset to a degree that is beyond normal for that individual. The latter signs, if present, are especially seen during times of bathing and clothing. Signs of neglect include the following: skin rashes and the like, malnutrition, dehydration, untreated illnesses or injuries, absence of necessary medication, and/or frequent visits to hospitals for unaccounted for or vague injuries/illnesses. The perpetrator of neglect typically threatens, intimidates, and isolates his or her victim (Anonymous "Warning," 1996). In addition to the warning signs, Bond (1986) states that one can be relatively sure that when an elder is physically abused, that elder is also being emotionally, financially, and medically abused.

A relatively short, yet comprehensive list of risk factors and characteristics for elder maltreatment (Wolf, 1996) is additionally provided. The first risk factor is when an unhealthy dependency exists of the perpetrator onto the victim, or more rarely, vice-versa. The second risk factor is if the perpetrator is in a disturbed, psychological state. The third risk factor exists when the elderly victim is frail or viewed as frail and/or disabled. The fourth risk factor deals with the isolation of the elderly victim from all

others outside the caregiving environment. The final risk factor is present when alcohol/substance use or abuse occurs on the part of the perpetrator.

Since the given warning signs and risk factors are so commonly notated to be indicative of elder maltreatment, a study was performed with 328 various type elder maltreatment cases that were reported to elder abuse programs in three states. Drawing from the results of this study, three profiles for elder maltreatment emerged. The first profile, the physical/psychological abuse profile, is that of an elder who is typically in poor emotional health but, is relatively independent when it comes to being able to take care of the needs of daily living. The second profile, the neglect profile, is an elder who is likely to be widowed, very old, physically and mentally impaired, and isolated from others. In the neglect profile, the elder is very much dependent on others. The last profile, the financial abuse profile, is an elder who is commonly unmarried, isolated, and lonely (Wolf, 1996). Reiterating that which was mentioned with warning signs and risk factors, a specific case may not identically match any of the three profiles. The main purpose of the profiles is to aid in identifying risk factors and, therefore, should be viewed only as guidelines, not rules.

Similarly, just as typical characteristics of those who are abused have been identified, the same is true for those who are the perpetrators of abuse. Since the elderly are living in noninstitutional settings, such as individual households, or in institutional settings, such as nursing homes, different characteristics for the abuser exist, dependent upon which setting is involved.

Within a noninstitutional setting, Bennet and Vernon (1995) state the following as characteristics of an abuser: "physical, functional, or cognitive impairment, alcohol and/or substance abuse, and dependence on elderly for financial support and housing." Wolf (1996) takes it further and distinguishes categories of characteristics/risk factors. In the study of risk factors, 328 elder maltreatment cases were involved, and the following factors were identified and defined. The first factor, physical/psychological abuse, shows that abuse is employed mostly by immediate family, including spouses and grown children living outside or inside the elder's home. The abuser typically is financially dependent on the elder and it is shown to be common for this abuser to have a history of psychopathology. The second factor, neglect, shows that the elder is, in most cases, perceived by the abuser as a source of stress. The final factor, financial abuse, shows that the abuser possesses monetary greed or a financial dependence on the elder.

In the same study as above, it was notated that adult children were more likely to maltreat their elderly parents by either neglect or psychological abuse. The spouse, as an abuser, typically verbalizes excessive complaints of medical problems and an overall declining physical health. As a side note, in order to show the magnitude of spouse abuse, since it is not commonly mentioned, a Boston study will be discussed. The study, involving 2,000 cases, concluded that spouse abuse (58%) was more prevalent than adult children (24%) abuse (Wolf, 1996).

Regarding maltreatment in institutional settings, Pillemar and Moore administered a telephone interview to 577 staff members in 31 long-term-care nursing homes.

Abusive behavior was found to be present in the facilities. Those individuals who were at greatest risk to become an abuser were identified as staff members who were contemplating terminating employment and who perceived the elderly as one perceives little children (Goldstein, 1995). Information for this setting was also able to be obtained from the Medicaid Fraud Control Units reports, covering 1987-1992. These reports showed that, in most cases, a male was likely to abuse a male patient and a female was likely to abuse a female patient. In addition, the reports showed that although males are underrepresented in the profession, they are overrepresented in cases of elder maltreatment. Therefore, it is feasible to conclude that males may be more likely to commit elder maltreatment as shown by these reports and as previous research corroborates. Distinguishing between the different job titles of the employees, nurses' aides were shown to commit elder maltreatment to a greater degree than other employees. The latter may be partially due to the fact that nurses' aides are the largest occupational group employed in a nursing home (Cikovic and Payne, 1995). Adding to this information, Wolf (1996) states that, based upon a study covering 35 states conducted in 1988 by the Office of the Inspector General/ Department of Health and Human Services, nurses' aides and orderlies are the primary abusers of the elder in nursing homes except for that abuse which is termed "medical neglect." The same study also identified visitors, family, and other patients as potential perpetrators of elder maltreatment.

Regardless of the setting in which the maltreatment occurs, the impact of gender and racial differences is not clear as of yet. However, adult protection programs' statistics show adult female children are more likely to commit elder maltreatment than adult male children. In dealing with ethnic populations, perceptions of elder maltreatment may differ from a given community's standards. An example of the latter is when a research team found that at least one Native American tribe believed that elder physical abuse was/is a problem of the community and not a shortcoming of the perpetrator. Another example is when a study showed that Korean-American elderly women find family unity and harmony to hold greater value than individual well-being. Hence, an abusive situation in one culture may not be viewed as such or given as much, if any, significance in another culture, such as in the culture of the Korean-American elderly women (Wolf, 1996). Clearly these studies are a good beginning for a body of research on this topic but, further research is necessitated.

As one may recall, noninstitutional elder maltreatment is by a person who has a special relationship with the elder, such as an adult child, in the given environment. Institutional elder maltreatment is by a person who has a contractual/legal obligation to provide care for the elder in the given environment, such as a nursing home ("National Center," 1996).

In the noninstitutional setting a study, which was previously mentioned, was conducted with 2,000 elders residing in the Metropolitan Boston area. From this study, it was found that 3.2% of the elders had experienced physical abuse and/or neglect since

turning 65 years of age. This same study, with the addition of a financial abuse category, was conducted in Canada. The new study found that financial abuse was the most prevalent form of abuse (Wolf, 1996). Therefore, had the financial abuse category been included in the original Boston study the results may have been similar to those found in the Canada study. One further study, employing written questionnaires and clinical evaluations, was conducted in a small semi-industrialized town in Finland. The findings were discussed in terms of gender. A prevalence rate of abuse for men was found to be 2.5% and the rate for women was found to be 7.0%. The prevalence rate for both sexes was 5.4% (Wolf, 1996).

Maltreatment in a noninstitutional setting is likely to be of a hierarchal nature. Suzanne Steinmetz, a researcher at the University of Delaware, stated that based upon research, a person employing physical and medical abuse are likely to be employing other types of abuse. Although an individual may use emotional abuse and not physical abuse, this is not likely to occur the other way around (Bond, 1986).

Due to all the above surveys being based upon self-reporting, the findings are most likely to be showing an underestimation of the prevalence rather than an exaggeration. On a more positive note, Wolf (1996) notates that state reports for elder abuses cases have shown a steady rise over the years. When first summarized in 1987, the numbers reported were 117,000 nationwide. In 1991, the numbers reported were 227,000. The rise is attributed to a heightened awareness of the problem by the public and to better devised systems for reporting.

The true, or as close to true as possible, prevalence rate for elder maltreatment in an institutional setting is not known. Few studies have been conducted in a scientific manner for this setting. One reason for the lack of a prevalence rate is that maltreatment in an institutional setting may often go unchecked. The institution may be poorly regulated and only sporadically inspected. Further, when an elder has no immediate family or friends to intervene on his/her behalf, he/she is totally dependent upon the institution's staff (Bernstein et.al., 1997). Hence, most often, as the saying reads, "What happens behind closed doors, stays behind closed doors."

Despite this hindrance to research, there are well-known types of maltreatment which occur in institutions, such as nursing homes. Some examples of typical maltreatment include rough handling, lack of or improper feeding, inattentiveness to the helpless, improper care or neglect to care for skin problems such as bedsores, and unnecessary restraint measures being utilized (Littwin, 1995).

Among the first of available institutional studies was one conducted by Pillemar and Moore, in1990, which was designed to measure if and how much verbal aggression, physical force, and violence existed, widespread across nursing homes. Staff attitudes and behaviors which resulted in elder maltreatment, defined as physical abuse, were the focus. Though the study does not provide an incidence rate, it does demonstrate that inappropriate patient management does take place in institutions. In the study, the sample consisted of 577 nurses and nurses' aides from 32 nursing homes in New Hampshire. Astonishingly, results showed that 36% of the sample had been witness to at

least one incident of physical abuse against a patient in the preceding year by other staff members. In fact, 10% admitted to committing at least one act of physical abuse against a patient. In dealing with psychological abuse, 81% of the sample witnessed at least one act against a patient in the preceding year by other staff members. In this case, 40% of the sample admitted to committing such an act. It was found that, most often, the maltreatment involving physical abuse was excessive use of restraints and that involving psychological abuse was yelling in anger toward a patient (Wolf, 1994).

A second study, carried out by the Office of the Inspector General/United States Department of Health and Human Services covered 35 states and surveyed 232 persons either directly or indirectly involved with nursing home care. During 1988 alone, the 35 states received 11,331 complaints on elder maltreatment in a nursing home. The complaints were typically of physical abuse, emotional abuse, or all forms of neglect -- physical, verbal, or emotional (Wolf, 1994).

In order to show the extent of some of the elder maltreatment acts that occur in nursing homes, reference will be made to the 1987-1992 Medicaid Fraud reports which were mentioned previously. The reports are published ten times a year and contain information dealing with the prosecution of elder abuse by fraud control units all over the country. The following were a few of the acts notated on these reports: a nurse improperly changed the dressing on a patients arm by cutting the dressing off with a sharp instrument, a patients arm was twisted, a nurse's aide caused irreparable damage by hitting the patient with fist and scratching the patient's cornea causing the patient to

be totally blind since the patient had already lost vision in the other eye due to glaucoma, patient hit on head with hairbrush, and urine soaked shoe placed in patient's face (Cikovic and Payne, 1995). One must bear in mind however, the incidents notated were ones that came to the attention of the criminal justice system. Therefore, other incidents of elder maltreatment that were of a "more minor degree" or which were not reported, were not able or available to be included in these reports. One question that is likely to come to mind now is why would anyone commit such acts against another human being, especially an elder. The answer that certain stress factors, such as poverty, loss of family support, job status, etc. is not true according to available research to this date (Wolf, 1996). In addition, a present controversy exists as to whether a cycle of violence theory is responsible for the maltreatment. The theory, as stated by Johnson (1984), holds that victims of maltreatment, at one time or another become perpetrators of maltreatment, especially against his/her abuser if possible. For now, one must decide for oneself whether he/she wishes to adopt this theory.

Common reasons are given and have been proven to be factors leading to maltreatment by various studies to date. A few factors which may lead to elder maltreatment include the stress of the caregiver, drug/alcohol use or abuse by the caregiver, deteriorated mental and physical conditions of the caregiver, financial problems of the caregiver, ignorance of caregiving roles, or the elder may be abusive and provoking toward the caregiver. Other dominant theories as to why elder maltreatment occurs is that of

retaliation, increased life expectancy, lack of close family ties, and unresolved conflict from childhood to mid-life.

Critics of a combined approach for discussing noninstitutional and institutional settings as a group allude to different factors which lead to maltreatment within each of the two settings (Kosberg, 1996). Therefore, in an institutional setting, some agree that additional factors are likely to contribute to why elder maltreatment occurs. The factors spoken of include high staff turnover, inadequate supervision, and an unbalanced staff to patient ratio. Staff stress can account for a great deal of the factors which are likely to lead to maltreatment. Due to stress, Cohen-Mansfield (1995) states, "Behavioral manifestations of the individual's response include flight or fight reaction, violence, total inaction, inability to function, and the like." The behavioral manifestations give way to a deteriorated quality of care that is likely to occur and the stress often attaches itself to other caregivers as well. Hence, incidents on the job may lead to violence as supported by previous research. The control of patients is typically one of the greatest difficulties noted by a staff member and maltreatment is often seen as one way to cope with the situation (Cikovic and Payne, 1995).

Overall, regardless of the setting, as long as the perpetrators are rewarded/reinforced by obtaining the desired results given by these acts, the probability of maltreatment occurring again in the future is highly increased. Along with this problem, another problem is that of the struggle for finding definitive causes for the maltreatment which

can be traced back to the lack of a consistent definition as to what qualifies as elder maltreatment.

Although it is true that many difficulties exist in defining elder maltreatment and all which it encompasses, with special emphasis placed on prevalence data, studies have been conducted to aid in the matter. Granted, not nearly the amount of research has been conducted that need be, but, a base has been set. Regarding this topic, it is necessary to distinguish between studies conducted in a noninstitutional versus an institutional setting.

To begin, a study conducted in a noninstitutional setting in Alabama surveyed fifty elders, those adults being 62 years and above, and their primary caregivers. One area surveyed was where one thought elder abuse was most likely to occur. Elders responded that the maltreatment was most likely to occur in a nursing home (45.9%), while the caregivers responded with the elder's home (41.6%). The results of another area surveyed showed that when questioned about the best, most appropriate context for dealing with elder maltreatment, elders responded with the family and/or social service agencies while the caregivers responded, to a greatly more significant degree, by identifying the court system as the best context (Johnson, 1995).

A second study in a noninstitutional setting was completed in conjunction with the Adult Protective Service Unit (APS) of the Forsyth County Department of Social Services. To review, APS units are community-based agencies established in order to investigate and protect the adult and elder population from abuse, neglect, and exploitation. In this study, 123 cases of elder maltreatment, elders being those adults 60

years and above, reported from 1985 - 1991 to the above APS unit were analyzed. It was found that unconfirmed reports were more likely to involve elders residing in a nursing home. Through interviews with APS staff, evidence suggests that this is greatly due to disgruntled employees filing false charges. Findings also revealed that the most frequently substantiated charge was exploitation of the elder's resources (Goodrich, Hwalek, Neale, and Quinn, 1996).

Regarding institutional settings, a 1986 report of a study contained in the National Academy Science's Institute of Medicine, notated that conditions in United States' nursing homes are "shocking and deficient." It was shown that federal regulatory structures paid greater attention to the nursing homes' ability to provide care and did not focus on how the care was provided nor how the care affected the elder. Adding to this study, the Research Triangle Institute's Program on Aging and Long-Term Care found when nursing homes' quality of care is improved, elder residents must undergo fewer hospitalizations (Rovner, 1995).

Few statistics exist for the various component areas which are contained under elder maltreatment in institutional settings. One statistic that does exist is that elders, defined as 65 years of age and above, have a 42% probability of being admitted to a nursing facility. Also, in 1994, of the complaints filed against nursing homes through the ombudsman program which monitors care for institutionalized elders, 35% dealt in the area of resident care ("Lack of State," 1995). Regarding the percentages of those living in nursing homes it was indicated that in 1990, 1.6 million elders, defined as those

adults 65 years and above, lived in nursing homes. Breaking this figure down, 1% of elders 65-74 years of age resided in a nursing home while 1 in 4 elders 85 years of age and above did. Viewing this in yet a different way, in the same year, 6% of the age group 75 to 84 resided in nursing homes while 24% of those elders 85 years and above did as such ("United States," 1995). The National Institute of Mental Health Facility Survey and National Nursing Home Survey results show that nearly 70% of nursing home residents have mental health needs. Typical staff had/has not obtained training for dealing with these needs (Ganzini, Goldsmith, Joseph, McWhorter, and Rooney, 1995). Finally, surveying United States workers in the field, a study found that these workers indicated that a great deal of the elderly with whom they have been in contact tend to prefer autonomy over personal safety (Bennett and Vernon, 1995).

Since it is difficult at times to detect elder maltreatment, various screening devices are made available to qualified individuals, such as social service agency workers, doctors, etc. The devices range from fast, brief screeners to more elaborate, thus longer screeners. A few that are currently available will be discussed as follows.

One screening instrument, the Qualcare Scale developed by Phillips, Morrison, and Young, in1990, evaluates the quality of care provided by a caregiver for an elder. Showing whether the caregiver fulfills the needs of the elder is this screener's main purpose. Thorough examinations of this scale, as notated by Archambault et. al. (1995), have shown it to be valid and reliable. Therefore, this being true, the scale is a good

measure of detecting whether a possibility exists that an elder is being maltreated in his/her living environment (Archambault et. al., 1995).

Another screening instrument available is the Brief Abuse Screen for the elderly (BASE). This instrument was designed by Reis and colleagues in 1993. It was designed for screening specific types of abuse, and the need for immediate treatment or intervention. Reliability and validity studies for this instrument have shown to be at, or above, acceptable levels. In fact, in one validation study, "trained home-care intervenors" agreed on the presence or absence of abuse 86% to 90% of the time (Nahmiash and Reis, 1995).

The assessment instruments are helpful, however, none of them either independently or together can replace a thorough assessment via interview and/or clinical evaluation. Therefore, doctors, psychologists/psychiatrists, and other professionals play a very important role in detecting elder maltreatment.

Often an elder is only seen by family unless a visit to a doctor is necessitated. As quoted from Pillemar and Wolf (1994), "Socialization is often missing in the lives of these abused elders." Hence, having a doctor detect the maltreatment may be the only chance for the elder. Answering the silent call for help, the American Medical Association (AMA) brought forth questions that need to be probed in its "Diagnostic and Treatment Guidelines on Elder Abuse and Neglect," which it issued in 1993. Robert Mcafee, immediate past president of the AMA states that doctors just are not asking the right questions and therefore, not making the appropriate referrals.

He states, " Any doctor who treats adult patients has seen at least one victim of family violence in the past two weeks." However, whether the latter be true, a survey of doctors in Seattle found that many doctors view questioning about elder abuse as one would view opening "Pandora's Box." The doctors cited fear of being incorrect, powerlessness if correct, among other reasons as explanations for the latter (Anonymous "AMA," 1996). Thus, the manual provides these and other doctors an appropriate way to initiate the topic and ways in which to respond to a potential problem.

Another way developed for aiding in the interview process is The **PR**ogressive **IN**terview **T**echnique (PRINT). This method is designed to aid in getting more information out of elder maltreatment interviews. It relies on statement content analysis which was developed by Sapir in 1976. Using statement content analysis, an interviewer listens to the way the victim and the caregiver refer to one another for clues to possible maltreatment. An example is that one would listen for "we" which is indicative of a closeness between people and "he, she, it", especially when both parties are in the same room, which is indicative of a gap between people. This logic is to be used throughout the entire interview (Formby, 1996).

In an institutional setting a nurse typically sees the elder on a regular basis. The nurse must stay aware of any and all changes in the elder's cognitive, psychological, and emotional functioning in order to be able to sense if maltreatment may be occurring. Fulmer, a nurse and professor at New York's Columbia University School of Nursing,

suggests that a multidisciplinary team be involved because what one worker, such as a social worker, doctor, or other, may not see, another may (C.M., 1993).

Consequently, if elder maltreatment is suspected, whether the suspicion originates from the observation of warning and risk signs or screening devises, it needs to be reported. Many agencies and hotlines which focus on elder maltreatment exist. However, having the public be aware of the latter is typically not an easy task. Since elders are unlikely to report maltreatment due to fear of retaliation, not being believed, shame, or various other reasons, approximately 70% or more of reported cases are from third-party observers (Berliner, 1997). Though this number may look impressive, Toshio Tatara, director of the National Center on Elder Abuse, states, "We just don't know how big the iceberg is." She notes that elder maltreatment is more underreported than child or spouse abuse (Littwin, 1995). More often than not, even if an elder were to wish to file a report, he/she would be unsure of where to file the report.

Typically, the best place to file a report is the Adult Protective Service (APS) agency because most cases are a social rather than a legal problem. In most states, APS is the principle agency responsible for taking elder maltreatment reports. It also handles adult cases, clients between 18 years of age and 59 years of age but, as the National Center on Elder Abuse (1996) published, approximately 70% of APS's caseloads are focused on elder maltreatment. Despite this, the cases reported to APS are believed to represent only a small portion of actual cases since a great deal go unreported.

Regarding mandatory reporting laws, as with the public's lack of awareness of service agencies, many physicians, psychologists, and others, may not be aware of these laws if they are enacted in their state. In order for the reporting laws to have a positive effect, all individuals held responsible within the law must be made aware of what must be reported and any and all repercussions for failure to follow the law. For example, using an excerpt from a 1990 Medicaid Fraud report, the penalties for not reporting abuse in the notated cases ranged from $200 fines to thirty day jail sentences (Cikovic and Payne, 1995). Hence, failure to report is coming to be viewed as comparable to actually committing the maltreatment.

Accordingly, if a complaint stems from an institutional setting, such as a nursing home, separate agencies or programs exist especially for taking these reports. One such program, created in 1971 and operating since due to the passage of the 1975 Older Americans Act, is the Long-Term Care Ombudsman Program. This program is operative in every state and was set forth to investigate and resolve nursing home complaints for elders sixty years of age and above ("National Center," 1996). In West Virginia (WV), the WV Commission on Aging, through this ombudsman program, monitors and addresses the needs of institutionalized elders (Schultz, 1983).

Another route for one to file a report is through a Medicaid Fraud Control Unit. Every State Attorney General's Office is required by law to have this unit and to have it investigate and prosecute Medicaid fraud and patient maltreatment in programs which

participate in Medicaid. The main focus of this unit is on institutionalized elders but, home health care services are often included as well ("National Center," 1996).

In addition to agencies, hotlines are available for reporting elder maltreatment. Most calls can be on an anonymous basis. One hotline, The National Eldercare Locator hotline, 1-800-677-1116, can even assist in locating the proper agency in the elder's area with which one needs to file a report (Berliner, 1997).

An organization that does not take reports, but does serve professionals and the public with information and expertise is the National Center on Elder Abuse, which was quoted earlier. This organization was established in 1994 by the Administration on Aging and is operated by those who possess expertise in the field of elder abuse ("National Center," 1996). Many, if not all, questions one may have can be answered by this organization.

The latter section on reporting was presented merely as a brief introduction to what routes one may take in reporting elder maltreatment and on no account is to be taken as a comprehensive listing of all possible routes. Numerous organizations, agencies, and hotlines are available. We, as the public, must become more aware of this fact. Answering these calls for help, various people and organizations, such as APS, have established intervention and future prevention tactics. This way, when filing a report, one will know what to expect next and that he/she is not acting alone.

After the filing of a report an investigation is conducted. Typically, in the case the report is unsubstantiated, the investigation will be halted and all identifying information

about the filer and alleged abuser will be destroyed from any and all records. However, if the report is substantiated, a client assessment will be provided by a local agency if the elder consents. In the case that the elder does not consent, an emergency court order may be obtained in order to provide involuntary intervention. Once the assessment is completed, recommended future actions will be set forth (Bernstein et. al., 1997).

Since researchers tend to agree that police intervention is an effective component in the battle against elder maltreatment, TRIAD programs have been set up in many areas. These programs, which originated in 1987 in Louisiana, work in an institutional setting as well as a noninstitutional setting. The program involves an agreement made by the sheriff, police chief, and members of senior organizations to "fight crime against elders and improve their overall quality of life." Next, SALT (Senior and Law Enforcement Together) Councils are formed. These councils identify problems which need to be addressed, develop a plan, and set forth action. These TRIADS and SALT councils already exist in many communities. However, if one does not exist in one's community, Betsy Cantrell, TRIADS program manager at the National Sheriff's Association, can be contacted at 703-838-5302 for help in getting a program initiated. It is proven, she states, ' " There is more authority when the person checking in [on an elder] wears a uniform (Anonymous "Seniors," 1996)."'

Another intervention/prevention system is that family members/friends can act as spokespersons for elders living in an institutional setting, such as a nursing home. Research was done which examined the frequency of nursing home visits related to

quality of care. Those families surveyed agreed that elders who had no visitors received a lower quality of care. Hence, visitors play a very important role in "keeping a watchful eye" over their loved ones (Collier, Lawrence, and Prawitz, 1994). To validate the latter point, Beatrice Perry of San Francisco, whose elderly mother is in a nursing home, says that she is not fully satisfied with what the nursing home is doing. She states that she often bathes her mother, does laundry, and other daily chores, and that these are duties the home is being paid to perform and is not doing so adequately, if at all. She says of nursing homes, "You have to stay on top of everything (McLeod, 1995)."

Banks and other financial institutions have become aware of the seriousness and high prevalence rate of elder maltreatment. Financial exploitation is an enormous problem for elders, as noted earlier. Therefore, these establishments are setting up tougher measures and becoming more aware and more sensitive as to the special needs of elders.

Intervention is a key word when dealing with elder maltreatment. As an example, Nahmiash and Reis (1995) published a model intervention team. This team consists of a home-care team, a multidisciplinary team, a volunteer expert team, volunteer buddies, an empowerment support group, and a community senior abuse committee. In defining these teams, a home-care team is a group of trained people who represent a basic intervention unit. A multidisciplinary team is a few home-care team members who confirm/disconfirm elder maltreatment and plan intervention strategies. A volunteer expert team is a group of volunteer consultants who have been deemed experts on the issue. Volunteer buddies are volunteers who are matched to an elder maltreatment

victim in order to provide support and encouragement. An empowerment support group is a group in which elders can discuss problems, solutions, and resources. The group gives the elder back his/her "internal locus of control." Finally, a community senior abuse committee is a group of volunteers who work as an independent unit and address such components to the issue as advocacy functions. As a side note, it is important to keep in mind that this is a "model" intervention team -- an example. Not all teams will possess all, if any, of the exact components. This model is a good starting point when deciding how to arrange an intervention team.

At present, it is not uncommon for intervention/prevention strategies to be uncoordinated in that they do not act together as a unit, instead they act as separate entities. Also, many programs lack the number of professional staff and volunteers needed due to insufficient funding and legislative restrictions. However, regardless of what intervention/prevention methods are established and utilized, something is been done for the maltreated elders and their loved ones.

In conjunction with reporting, there are laws and acts established which protect elders and their families, some of which carry harsh punishments for the perpetrators of elder maltreatment. Accordingly, Wolf (1996) states that all of the fifty states have some type of legislation which enables the states to protect and provide services to vulnerable adults, such as elders.

One law created to help protect elders from maltreatment is the 1987 Amendments to the Older Americans Act which holds a separate provision titled

Elder Abuse Prevention Activities, Title III, part G. Through this law, states are required to develop and provide public education on identifying abuse, neglect, and/or exploitation. Beyond this education, procedures must be available and made public, to individuals and agencies, on how to file, accept, and investigate an elder maltreatment report (Goodrich et. al., 1996).

Regarding the reporting of elder maltreatment, as of 1995, 42 states possessed mandatory reporting laws. Only the following states possessed voluntary reporting: Colorado, Illinois, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin. All states are subject to differ on what information is required/requested at the time of the report (Goldstein, 1995).

Specifically, in West Virginia mandatory reporting is a law. In the state, the law encompasses all medical, dental, mental health professionals, Christian Science Practitioners, religious healers, social workers (including the Department of Human Services Agency's staff), peace officers, and law enforcement officers. If any of the above people have reason to suspect or know of an incapacitated adult [any person who, due to physical, mental, or other infirmity is unable to independently perform the daily activities of life which are necessary to sustaining life and reasonable health] being subjected or having the potential to be subjected to abuse, neglect, or exploitation, then he/she must immediately file a report or cause a report to be filed with the local Department of Human Services. Institutional maltreatment is reported in the same manner. Failure to report may result in a fine of up to $100 and/or imprisonment of up to

ten days in the county jail. If the mandatory reporter has reason to believe that an incapacitated adult has died due to abuse and/or neglect, he/she is mandated to make a report to the appropriate medical examiner/coroner. In order to ensure that the reports are filed, it is notated that if a report is made in good faith, whether mandated or voluntarily, the filer of the report will possess immunity to any civil or criminal liability which might arise from filing the report. In summary, the above people listed are those mandated by law to report, however, any person, including the incapacitated adult if able, may make a report under the permissive reporting section of the law ("West Virginia," 1997).

Laws which inflict punishment upon perpetrators of elder maltreatment vary from state to state. Elder abuse may not be considered a crime in some states, depending on the state's statute. Despite the latter, elders are generally still covered and protected since most physical, sexual, and financial abuse are considered crimes in all states. On the other hand, when dealing with emotional abuse, neglect, and/or self-neglect, some states provide prosecution for these acts and some do not ("National Center," 1996).

Upon writing this review, bill H.B. 2084, which went into effect ninety days from its passage on April 8, 1997, by the WV Legislature added a new section to a WV Code which covers the abuse of vulnerable adults. A vulnerable adult is defined by the delegates as an incapacitated adult, which was defined previously. In addition, the delegates make a point to state that an elder can be contained within this definition. As a result of the bill being passed, intentional abuse/neglect of a vulnerable adult will be

a felony. If the perpetrator is convicted, he/she may be sentenced to the penitentiary for no less than two years and no more than ten years or to a county jail for no more than twelve months along with a fine of no more than $1500. If an individual permits someone else to abuse/neglect a vulnerable adult, the law holds that it is a misdemeanor. If the individual is convicted, he/she may be fined no less than $500 and no more than $1500 and/or imprisoned for no less than ninety days and no more than one year. However, if it is a vulnerable adult's independent decision to rely on spiritual means by practices of a recognized church or religious domination rather than any type of medical treatments, this is not to be considered abuse or neglect (Wagner and Riggs, 1997)

As mentioned, laws and acts are established so as to protect an elder and his/her loved ones. One such act, the Americans with Disabilities Act (ADA) 1990, is especially relevant to elders living in nursing homes since, to be covered by this act, the individual must possess a disability. According to the act, a disability is present if the person has a mental/physical impairment, which limits at least one or more life activity, such as breathing, a record of a mental/physical impairment even if misdiagnosed in youth, or is regarded as having an impairment which limits a major life activity even if the impairment does not exist. Nursing home residents typically fit into one of the above three categories. In addition, this act is relevant to nursing home residents due to the rights given to them and contained in the nursing home reform amendments of the Omnibus Budget Reconciliation Act of 1987 (OBRA).

ADA protects an elder's family and loved ones by prohibiting discrimination. Discrimination occurs when loved ones are denied access to the elder, or any privileges extended to others because, for example, questions are raised over the quality of care that the elder is receiving, or the filing of a complaint, or due to aiding in an investigation. If the nursing home staff, directors, etc., utilize such actions as intimidation or threats and/or interfere with any other rights covered by the ADA, they are also in violation. Thus, a discriminated against individual has grounds for initiating legal proceedings (Gottlich, 1994).

OBRA 1987, alluded to previously, is more specific in its provisions. OBRA 1987 contains provisions for the use of restraints and medicine, among other provisions for nursing home residents. First, it has been reported that physical restraints are used in 25% to 85% of nursing homes. Considering the statistics, OBRA 1987 states that nursing home residents possessing behavioral disturbances are to be handled more safely, without physical restraints. Often, the latter leads to more effective management. Secondly, OBRA 1987 states that these individuals' "drug regime" is to possess no unnecessary medicine. An unnecessary medicine is any used in excess, any which duplicates another medicine, any given for an excessive duration, etc. (Streim, 1995). When these provisions along with those in ADA are carried forth, elders residing in nursing homes and their loved ones are more apt to receive the care and rights that they should receive and have come to expect.

Nevertheless, laws nor acts are the "cure-all" for elder maltreatment. As with other methods of prevention and intervention, problems are contained within the structures themselves. For example, if a law or act is not written properly, an elder may be forced to relinquish control of his/her affairs even if he/she is capable of solely taking care of them. Another problem is, as Bond (1986) states, "filial responsibility laws" which exist in some states. The law forces adult children to care either physically and/or financially for elderly parents. It has been speculated that the law, instead of helping the elder, may be setting the scene for increased maltreatment of the elder population. However, laws and acts are proven to be more beneficial than they are harmful. It is a matter of weighing the benefits.

Summing up, elder maltreatment is a present reality. Deke Richards, a social worker for the Gainesville-Hall County Senior Opportunity Services Division, goes as far as to say that he thinks, like child abuse, elder abuse has been there all along. He feels it's just about where the public awareness of child abuse used to be (Grissett, 1982).

To date, limited progress has been made in understanding what elder maltreatment entails and its scope. However, at present, and as speculated for the future, the numbers of reported cases are increasing at a steady rate (Wolf, 1996). Hence, new research, including that for obtaining more valuable, valid and reliable, measures for detecting maltreatment is in critical need. Frazier (1994) goes a step further by stating that underlying attitudes of society need to be examined for how they "set the stage" for elder maltreatment. In 1990, at a National Aging Resource Center on Elder Abuse , an expert

panel agreed that more outcome studies for agencies responsible for intervention are necessitated (Goodrich, 1996). Many researchers hold that more extensive education (e.g., workshops), more training and in-service training, increased certification requirements, and different employee selection methods need to be established in order to help prevent future elder abuse from occurring.

Taking somewhat of a different view, some experts (Grissett, 1982) propose that America should look at other nations as how they handle the care of their elderly. Other countries, such as Denmark and Great Britain, are able to make old age a comfortable stage of life and even a stage of life of which to look forward to reaching. The standard of care that these countries make available for their elderly ensures the latter. America is capable of doing the same.

While the true scale of elder maltreatment is unknown, it is not feasible to treat it as a minority problem. Estimates have been provided as to the true scale, but whether it be 1, 100, or beyond should not be of matter. Liz Capezuti, an assistant professor at the University of Pennsylvania School of Nursing states, ' " You don't have to be an expert to know that no one should die like this."' ' " They don't deserve that kind of care (Brienza, 1995)."' However, as Griffin (1996) points out, how can an elder defend himself/herself against the abuse when the perpetrator is the caregiver? The elder may have no one else to turn to or may not be aware that there are people and agencies that can help. We, as a society, have no concrete answer for this dilemma as of yet. Hence, elder maltreatment will no doubt continue to be a great problem for the next century.

As for the future elders, Silverstone (1996) believes that they will be more confident about being old. They will, she states, join together as a unit and redefine old age and all that it entails.

Appendix B

Packet

Letter of Agreement

I understand that Debra Evans, a Psychology Graduate Student at Marshall University Graduate School, wishes to conduct a research project as part of her thesis at this facility, *(Name of Facility)*.

This will entail recruiting senior citizens to participate and utilizing a small portion of the time the senior citizens spend at this facility. Our facility agrees to the above.

_____ _____

Date *Facility Contact*

_____

DEBRA EVANS, student
Marshall University Graduate College

Consent to Participate in a Research Project

I hereby volunteer to participate in a research study designed to measure my knowledge on the topic of elder abuse, neglect/self-neglect, and exploitation in West Virginia. The research will be conducted by Debra Evans, B.A., and a Psychology Graduate Student at Marshall University Graduate College. This study is to be used for a Masters Thesis.

I will be asked to provide demographic information (such as my age, etc.), answer a few questions on a questionnaire sheet, and respond yes/no to five case samples. I understand that I will be **anonymous**, therefore, my **confidentiality will be intact**.

Any questions I have regarding the study or my rights as a participant will be answered as best as possible by Debra Evans.

Participation in this study is voluntary. I have been given the opportunity to decide whether or not to participate. Refusal to participate involves no penalty or loss of any benefits to which I am entitled.

_____ _____

Date *Participant's Signature*

_____

Researcher's Signature

Informational Data

Age: _____

Gender: Male/Female **(Circle One)**

County of Residence: _____
How long, approximately, have you lived in the given county? _____

Residential Arrangements: Live Alone? _____
If no, with whom or where (nursing home, daughter/son's home, etc.) _____

Senior Affiliations (Clubs, etc.): List all in which you belong or participate.

_____

_____

_____

_____

Main Caregiver: (Yourself /anyone else that aids you in your daily living) _____
(Examples: Myself, My son, My neighbor, A nurse)

Did you drive here today? _____
If no, how did you arrive here today? (Senior Van, Bus, Friend, etc.) _____

Questionnaire

1. Has anyone ever discussed with you the characteristics of, or, what constitutes elder abuse, elder neglect, elder self-neglect, and/or elder exploitation?

Yes/No (Circle one)

2. If the answer to #1 is yes, what relationship was the person who discussed this topic with you? (Examples: Friend, Neighbor, Nurse, etc.)

_____

3. Have you ever seen or read any information dealing with elder abuse, elder neglect, elder self-neglect, and/or elder exploitation?

Yes/No (Circle one)

4. If the answer to #3 is yes, where did you see or read this information? (Examples: Library, Bank, etc.)

_____

5. Are you aware of where to report elder abuse/neglect/exploitation?

Yes/No (Circle one)

6. If the answer to #5 is yes, please list all places below.

_____

7. Would you report the abuse if you were the elder victim and the perpetrator was _____?

Family	**Yes/No (Circle one)**
Friend	**Yes/No**
Neighbor	**Yes/No**
Other	**Yes/No**

8. Have you ever, to your knowledge of the definitions of these terms, had any experiences with elder abuse/neglect/exploitation?

Yes/No (Circle one)

9. Have you ever been involved with any social service agencies or the legal system due to having experienced elder abuse/neglect/exploitation?

Yes/No (Circle one)

Case Sample 1

A 65 year old elder lives alone, with the exception of his/her cats, in a house near the city. The elder is independent -- takes care of own needs. Activities enjoyed include swinging on the porch, visiting with neighbors, gardening, etc. No car is available, therefore, the elder does not go into the city very much at all. Medical problems include high blood pressure that requires prescription medication on a daily basis. The elder's adult child lives only a few blocks away. He/She refuses to go and pick up the elder's medicine in the city which is only a few minutes away because "it is too much trouble." Due to this, the elder typically pays for a cab into and back from the city in order to pick up the prescription medicine.

Question: Based on your knowledge, would this case sample likely be an example of what the State of WV and Adult Protective Services define as elder abuse, elder neglect/ elder self-neglect, or elder exploitation?

Yes/No (If yes, circle which applies)

Case Sample 2

A 63 year old elder is a diabetic. While he/she was mentally competent, the ability to administer one's own insulin shots and other necessary medications was present. Since his/her mental functions have diminished, and no family exists, the neighbor (with whom the elder is close friends) was proclaimed the elder's legal guardian. The neighbor, being aware of the elder's strong faith to religion, felt that the elder could become even more religious and holy by not taking "man-made" medications. The elder is then relying solely on God, the neighbor felt. Therefore, the neighbor withheld all medications. When the elder would show symptoms of not taking the medications and ask why this was happening, the neighbor would reply by saying, "You and I both know this is what you really want."

Question: Based on your knowledge, would this case sample likely be an example of what the State of WV and Adult Protective Services define as <u>elder abuse</u>, <u>elder neglect/elder self-neglect</u>, or <u>elder exploitation</u>?

Yes/No (If yes, circle which applies)

Case Sample 3

A 76 year old elder is cared for by his/her adult child since he/she is no longer able to take care of own daily needs/activities. One day the elder came walking through the home naked after he/she had taken off the sleepwear worn the previous night. The elder was attempting to change clothing for the day. The elder was looking for the adult child for some assistance in dressing. The adult child, never having made any sexual advances in the past, began touching the elder in inappropriate places. When the elder fought back with what little strength he/she possessed, the adult child pushed the elder down on the ground and told the elder that, "I was only trying to help you get dressed."
The adult child then dressed the elder.

Question: Based on your knowledge, would this case sample likely be an example of what the State of WV and Adult Protective Services define as <u>elder abuse</u>, <u>elder neglect/elder self-neglect</u>, or <u>elder exploitation</u>?

Yes/No (If yes, circle which applies)

Case Sample 4

A caregiver, takes the elder for which she cares to the park one day. The elder is disabled and mentally retarded. The elder enjoys looking at all the different flowers and leaves at the park. While the caregiver was watching, the elder starts going towards the highway in order to cross over to a flower garden across the way which caught the elder's attention. Noticing this and in a panic, the caregiver, screaming for the elder to stop, caught up to the elder and tugged on the elder's arm with some strength trying to halt the elder from crossing the highway. The caregiver then took the elder to the emergency room after noticing the elder kept holding his/her arm. The elder was found to have a sprained arm from the tugging and therefore, must wear a sling for a few days.

Question: Based on your knowledge, would this case sample likely be an example of what the State of WV and Adult Protective Services define as elder abuse, elder neglect/elder self-neglect, or elder exploitation?

Yes/No (If yes, circle which applies)

Case Sample 5

A 72 year old elder, having extremely diminished mental capacities, is cared for by a caregiver. The elder is fully "in the hands" of the caregiver. The latter meaning that the caregiver has total control over the elder's financial affairs, among all other affairs. As part of the responsibilities, the caregiver pays all of the elder's bills. Hence, the caregiver was listed on the elder's checking account at the bank as an authorized user and signer. Every once in a while, the caregiver made out his/her check (to "Cash") for more than agreed to because he/she felt a raise was in order anyhow.

Question: Based on your knowledge, would this case sample likely be an example of what the State of WV and Adult Protective Services define as <u>elder abuse</u>, <u>elder neglect/elder self-neglect</u>, or <u>elder exploitation</u>?

Yes/No (If yes, circle which applies)

Appendix C

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