Elder Abuse: Cultural Contexts and Implications

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- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
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Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Director of Development and Academic Affairs

Sarah Campbell

Director Disclosure

The director has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is targeted to counselors, therapists, social workers and other mental health professionals who may identify and intervene in cases of elder abuse.

Accreditations & Approvals

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Course Objective

The purpose of this course is to increase the knowledge base of social workers, counselors, therapists, and other professionals about elder abuse, assessment, and intervention. This curriculum will focus on abuse against elders in domestic settings perpetrated by family members.

Learning Objectives

Upon completion of this course, you should be able to:

1. Summarize the historical context and scope of elder abuse.
2. Define elder abuse and the different forms of elder abuse.
3. Identify the general profile of the elder abuse victim.
4. Analyze the different classifications of perpetrators of elder abuse.
5. Discuss the various theoretical models to help explain the causes of elder abuse in domestic settings.
6. Explain how culture, race, and ethnicity color views about family and aging and definitions of and attitudes toward elder abuse and help seeking.
7. Discuss assessments for elder abuse victims.
8. Describe general mandatory laws for and ethical issues associated with elder abuse, including the role of interprofessional collaboration.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

HISTORICAL OVERVIEW

EMERGENCE AND SOCIAL CONSTRUCTION OF FAMILY VIOLENCE

To understand the emergence of elder abuse as a social problem, it is helpful to examine it within the historical context of family violence. It is often assumed that family violence is a recent phenomenon, perhaps because of the amount of media coverage to which we are exposed. However, it is not a recent development. Infanticide, for example, has been practiced since prehistoric times [1].

Spector and Kitsuse assert that a condition (e.g., family violence) becomes a social problem only when individuals and groups make claims that a condition is problematic and argue that the condition should be eradicated or that it is in need of intervention [2]. Child abuse, for example, came to the public's attention in the 1870s when the abuse of a specific young girl was "discovered." The Society for the Prevention of Cruelty to Animals asserted that this young girl should not be abused because, technically, she is an animal [3]. The focus on child abuse waned until the 1960s when Henry Kemp "rediscovered" child abuse, and his article "The Battered Child Syndrome" legitimized it as a social problem [4; 5]. The characteristics of this medical syndrome included traumatic injuries to the heads of young children, typically younger than 3 years of age. It became a serious medical problem warranting medical as well as legislative intervention [4].

Similarly, we tend to associate domestic violence with the 1960s, when the feminist movement brought this issue onto the national stage. However, assaults against women by their husbands or intimate partners were not a new social issue. Dobash and Dobash argue that domestic violence has always existed [6]. As recently as the 1970s, a Pennsylvania town had an ordinance that prohibited a husband from beating his wife after 10 p.m. on Sundays [7]. Until the feminist movement focused on the plight of battered women, minimal empirical attention was given to this condition [8]. In 1981, the first National Day of Unity was observed, and since 1984, Domestic Violence Awareness Week has been observed each October [7]. It is against this backdrop that elder abuse emerged in the 1980s as a recognized social problem.

EMERGENCE AND SOCIAL CONSTRUCTION OF ELDER ABUSE

As a form of family violence, elder abuse has existed for millennia, although it did not gain public attention until fairly recently. Anthropologists have described some cultures and societies that abandoned or killed the elderly during times of structural inequalities and tensions [9]. In cultures predominated by agriculture, the need for laborers and disputes over land inheritance fueled family conflict [10; 11]. In general, throughout the ages and certainly today, cultural norms dictate what is considered "productive" during the various cycles of the life span [9].

Burston, a physician, published an article about "granny-bashing" in the *British Medical Journal* in 1975, which promulgated the notion of elder abuse, and the media then began to use the term, which helped to reinforce the seriousness of the problem [12; 20]. By the mid-1980s, the gerontology literature began including works on elder abuse, and in 1980 the House Select Committee on Aging heard testimony about the "social problem" of elder abuse (referred to as "parent battering") in the United States [13; 19]. Shocking testimony was given about elderly seniors who were beaten, neglected, left in filth, and financially exploited by children, grandchildren, or caregivers [14].

In the United States, the conception of elder abuse was closely linked with the concept of child abuse [20]. The picture of a frail elderly parent dependent upon their adult child caregiver was disseminated, and because there was no statute for elder abuse at that time, lawmakers and service providers turned to the child abuse model with its mandatory reporting

laws [15; 20]. In 1974, an amendment to the Social Security Act created the Adult Protective Services (APS) [22]. At that time, the purpose of APS was to protect adults with physical and/or mental limitations [25]. However, the APS system became the solution when elder abuse became a public issue, allowing action on the matter without having to call on additional state funds [15]. Consequently, policies and programs were tailored to look like the child abuse and neglect model. For example, both child abuse and elder abuse models require the reporting of incidences of abuse through specific channels, the designation of certain professionals to report if incidences of abuse are learned, and penalties for violations. In both forms of family violence, a third party can intervene if there is suspected child or elder abuse [16].

In the late 1970s, there was a shift in attention to elder abuse in nursing homes. The Administration on Aging advocated including elder abuse prevention in the Older Americans Act [25]. In 1978, the Older Americans Act was amended to include the responsibility of each state to develop long-term care ombudsman programs to deal with elder abuse in nursing homes [17]. A public health perspective was also introduced in the 1980s, as the Centers on Disease Control and Prevention implemented more policies and resources in this area [25]. By the 1980s, research tended to focus on elder abuse rather than adult protective services, likely because elder abuse sounded like a more dramatic social problem [105]. In 1987, with the increased public interest in elder abuse, the National Center on Elder Abuse was developed by the federal government to more clearly define elder abuse and neglect as well as to promote awareness and formulate educational programs for elder abuse [17]. By 1991, there were mandatory reporting laws in 42 states; however, a study by the Government Accounting Office found that these laws were not effective in reducing elder abuse [105].

In 2003, Louisiana Senator John Breaux introduced the Elder Justice Act [115]. The title of the Act was meant to support the notion of elder abuse as a human rights issue—the right of all elders to be free from abuse and mistreatment [115]. In March 2010, the Elder Justice Act was passed. It was the first federal legislation enacted to detect, prevent, and prosecute elder abuse [28]. The goal of this act is to "better coordinate federal responses to elder abuse" [18]. As a part of its activities, the Department of Health and Human Services will implement forensic centers to develop elder abuse services, enhance long-term care services by providing more staff training, provide funds to states' Adult Protective Services for more research, detection, and prosecution of cases of elder abuse, and provide funds to long-term care ombudsman programs to respond to elder abuse in care facilities [18]. In 2015, the White House Conference on Aging was held, and elder abuse was identified as one of the four priorities in promoting the well-being of older adults [132].

The interest in elder abuse increased in the 1980s and continues today, partially due to the growth of the elderly population. According to the U.S. Census, in 2019, there were 54.1 million adults who were 65 years or older [31]. By 2060, it is estimated that there will be 94.7 million adults 65 years of age and older in the United States and they will represent 23.4% of the U.S. population [34; 210]. In the United States, persons 85 years of age and older are projected to number 19 million in 2060. This rapid growth is attributed to the aging of the baby-boomer generation, and the youngest baby boomer will be 96 years of age in 2060]. In addition, life expectancy has continued to increase. It is projected that by 2036, the number of persons 85 years of age and older in the United States will double, with the number tripling by 2049 [211].

Similarly, the ethnic minority elderly population is growing rapidly. In 2019, there were 12.9 million older adults (24%) in racial and ethnic minority groups in the United States [31]. By 2030, individuals who identify as racial/ethnic minorities will represent 28% of the U.S. population [21].

Between 2014 and 2030, the White population is expected to increase by 46%, compared with 110% for older racial and ethnic minority populations, including Hispanics (137%), African Americans (90%), American Indian/Native Alaskans (93%), and Asians (104%) [21]. These demographic trends have opened the eyes of policy makers and service providers to the needs of the elderly, and the specific needs of minority elderly populations.

Elder abuse remains a largely invisible problem, which is due in part to the fact that the elderly are frequently isolated. Frail elders often do not leave the house, perhaps seen only by a caregiver, allowing their abuse to remain behind closed doors [10]. Also, our society has some misconceptions about this period of life. We generally view the elderly years as "golden," as a period when one retires, travels, and spends time pursuing leisurely activities. Additionally, we believe that the family is a private domain, free from public scrutiny. These factors allow elder abuse to continue to occur in both domestic and institutional settings.

PREVALENCE AND SCOPE OF ELDER ABUSE

In a systematic review that represented 28 different countries, the overall prevalence rates of elder abuse was assessed at 15.7%; 11.6% had experienced psychological abuse [213]. It is estimated that approximately 1 in 10 Americans older than 60 years of age has been the victim of abuse, including physical abuse, psychological or verbal abuse, sexual abuse, financial exploitation, and neglect [23; 24; 214]. According to data from the National Intimate Partner and Sexual Violence Survey (NISVS), 14% of adults 70 years of age and older had experienced some form of abuse in the past year [215]. In a national study of older Americans (mean age: 75.5 years), 40% of women and 22% of men reported at least one form of mistreatment (i.e., emotional, physical, or financial) [40].

According to a national telephone survey, 1.6% of elderly respondents reported experiencing physical abuse in the past year; 5.2% recounted financial abuse, 5.1% neglect, and 4.6% emotional abuse [26]. In another survey study with 3,005 adults between 57 and 85 years of age, researchers found that only 0.2% disclosed physical abuse in the last year, 9% reported verbal abuse, and 3.5% indicated financial abuse [27]. In a 2020 study, 1.7% of older adults experienced polyvictimization (defined as experiencing multiple types of abuse) [142]. Not surprisingly, inability to accomplish activities of daily living places an individual at more than double the risk of polyvictimization.

The prevalence and scope of elder abuse in institutional settings, such as nursing homes, is not clear, in part due to lack of agreement about definitions [23]. Elderly neglect is typically conveyed as poor care; however, this is a very simplistic definition and does not take into account clinical and legal ramifications [29]. For example, is patient neglect due to staff's poor attitudes, medical negligence, human error, or some other factor?

In two studies on elder abuse in institutions, Buzgová and Ivanová reported that 54% of the staff from 12 different residential homes in the Czech Republic self-disclosed to having perpetrated some form of abuse on their elderly patients in the previous year; 65% of the staff witnessed another employee committing some form of elder abuse [30]. When patients were asked, only 11% reported having experienced some form of abuse by staff, and 5% witnessed another patient being abused by a staff member. A 2022 meta-analysis examined the prevalence rates of elder abuse in long-term care facilities [184]. Researchers found that neglect was the most prevalent (64%) in home care and verbal abuse was most prevalent (21%) in nursing homes. The most significant predictor of neglect was the patient's ability to carry out activities of daily living, with more limitation correlating to greater likelihood for neglect. In a 2019 systematic review, 33.4% of older adults in institutional settings reported psychological abuse, and 14.1% reported physical abuse

[216]. Strikingly, 64.2% of staff disclosed to abusing an elder resident. In a study with 1,002 relatives of elderly residents of long-term-care facilities, 16.2% stated their family member had experienced neglect, 13% reported emotional abuse, and 12.7% reported caregiving abuse, which was defined as mistreatment that stemmed from caregiving activities such as withholding or delaying drugs, over administration of drugs, inappropriate uses of physical restraints and forced feeding [32]. The authors noted the limitations of using family relatives as proxies; however, family members are often keen observers of abuse, and because the victim would not be identified in the study, the researchers felt that the relatives could be more truthful [32].

This was consistent with another telephone survey study of individuals who had an adult family member 65 years of age or older living in a long-term care facility [33]. Researchers found that 86% of participants reported that their elder family member experienced neglect, such as staff's failure to ensure personal safety and to provide food, water, and/or medications. Emotional or psychological mistreatment, defined as the elder family member being treated disrespectfully, not being allowed to talk or see family members, or being given the silent treatment, was reported by 79% of participants. In telephone survey of 452 adults with elderly relatives in nursing homes, 24.3% indicated that their relative experienced at least one incident of physical abuse by a staff member [217]. In a qualitative study with 16 family members, neglect appeared to be the most widespread type of elder abuse in nursing homes. Cases of elder abuse were linked to insufficient staffing, lack of individualized patient care, and poor leadership in nursing homes [212].

Sexual abuse experienced by elders in institutional care facilities has been minimally studied. The literature has documented that sexual offenders who sexually abuse elders in care facilities include employees, other residents, family members, and visitors to the facilities [35]. Perpetrators generally target victims who have mental or physical impairments. In one study, researchers found that the largest group of alleged sexual offenders consisted of employees of the facilities (43%) [35]. The majority of these employees provided direct care to the elder residents. The second largest group was other residents of the facility (41%).

As stated, problems in obtaining prevalence rates stem from a lack of a definition of elder abuse [36]. For example, should the definition focus on acts of physical, psychological, verbal, sexual, and/or financial abuse? Some differentiate between different types of neglect: passive and active [36]. Passive neglect or benign neglect refers to when the caregiver is not aware they are injuring or causing harm to the elder, while active neglect is intentional harm [36]. Although the National Center on Elder Abuse (NCEA) recognizes the value of each existing definition, using different definitions will affect the outcome of the scope of elder abuse [23].

Methodologic issues, such as sampling and recruiting participants, are complicated because elder abuse is a private and sensitive topic matter. When race, culture, and ethnicity are added to the equation, it becomes even more complicated. Issues of translating and back-translating instruments, ensuring linguistic equivalence of constructs, and hiring linguistic and culturally proficient interviewers are some issues that arise with cross-cultural research. Consequently, to get a sense of the scope of elder abuse in ethnic minority communities, this course will focus on nonprobability sample studies.

SCOPE AND TRENDS OF ELDER ABUSE IN ETHNIC MINORITY COMMUNITIES

There are few empirical studies that look at the scope of elder abuse in ethnic minority communities. In a large-scale study with a representative sample of 5,777 older Americans obtained through random digit dialing, there were no racial or ethnic differences in rates of emotional and sexual elder abuse among White and non-White individuals (self-classified as Black, Pacific Islander, Native American or Alaska Native, Asian, Hispanic, or other). There were slightly higher rates of physical elder abuse for non-White people compared to White people (3.0% vs. 1.4%, respectively) [37]. In another study with 200 Latino individuals 65 years of age and older, researchers found that 40.4% of the participants had experienced some form of abuse or neglect in

the previous year; 25% disclosed experiencing psychological abuse, 10.7% physical abuse, 9% sexual abuse, and 16.7% financial abuse [38]. Some have hypothesized that Hispanic cultural beliefs that promote sharing resources with family members could potentially contribute to financial elder abuse [228].

There have been very few studies of Native American elders and victimization. A 2018 study found that financial abuse was the most common form of elder abuse among this population [218]. An analysis of a sample of 195 American Indians and Alaska Natives using the National Elder Mistreatment Study dataset, found that the overall prevalence rate of elder abuse experienced in the past year was 33%, which was higher than the 17% reported by the larger study population [230].

One study found that 63% of African Americans with impaired decisional capacity experienced some form of financial exploitation [219]. Another study found that the rate of past-year financial exploitation was two to three times higher among African American elders than the national rate [220]. In a telephone survey in Pennsylvania, 693 non-African American and 210 African American persons 60 years of age and older were asked about their experiences with financial and psychological abuse perpetrated by a spouse, child, family member, or another trusted individual [41]. Twenty-three percent of the African American respondents indicated they had experienced financial exploitation since turning 60 years of age compared to 8.4% of their non-African American counterparts. The figures were higher for African Americans regarding psychological abuse (24.4%) compared to the non-African American respondents (13.2%). In another study, Dimah and Dimah examined gender differences among African American elder abuse victims and perpetrators [42]. Forty-eight cases of substantiated elder abuse in a service agency were examined. They found that male elder abuse victims experienced more physical abuse (85%) than their female counterparts (42.9%). African American perpetrators of elder abuse were found to be more often related to their victims. Finally, financial exploitation was a common form of elder abuse, affecting 53% of the male victim cases and 54% of the female victim cases.

In a large-scale study conducted in Chicago with Chinese American elderly, the overall prevalence rate of elder abuse was 15%, with psychological abuse being the most common (10%) [232]. Chang and Moon conducted a study with 100 Korean immigrant elders and found that 34% had witnessed or heard about elder abuse that occurred among friends, family members, or acquaintances [43]. Financial abuse was the most common form. A common example of financial abuse cited from this study was a son stealing from his parents' Supplemental Security Income checks [44]. In a 2019 quantitative study, two groups of older Koreans between 60 and 79 years of age—those residing in Korea and those in the United States—reported similar rates of abuse (23% and 26%, respectively) [221]. In both groups, declining health was correlated with abuse.

In Asia, the topic of elder abuse is receiving increased empirical attention. In a study of Korean caregivers and their elderly family members with various types of physical and cognitive abilities, the most common forms of elder abuses were psychological abuse and neglect [45]. Almost one-fifth of respondents (18%) disclosed to confining the elder family member in a room and 10% admitted to having hit the elder. In a large-scale study conducted in China, 2,039 individuals 60 years of age and older were interviewed, and 36% of the participants indicated they experienced elder mistreatment [46]. Specifically, the prevalence of physical elder abuse was 4.9%, psychological abuse was 27.3%, caregiver neglect was 15.8%, and financial mistreatment was 2% [46]. In another study in China, psychological abuse in the past year was reported by 11% of children of elderly parents [233]. Risk factors for abuse included having depression, being alone (e.g., divorced, widowed), and having a labor intensive job. In another survey study of individuals 60 years of age and older living in an urban area in China, 35% of the sample (32% men and 42% women) reported elder abuse and neglect [47]. Caregiver neglect was the most common form (16.9%), followed by financial exploitation at 13.6%. In Hong Kong, Yan and Tang conducted a survey study on the risk factors of elder abuse with 276 elder Chinese individuals, 27.5% of whom admitted to having experienced at least one type of

abusive behavior perpetrated by a caregiver during the past year [48]. The findings of the study also found that verbal abuse was the most prevalent, at 26.8%, while violation of personal rights (5.1%) and physical abuse (2.5%) were less common. Participants who had visual or memory problems and who were dependent on their caregivers were more at risk of general abuse and verbal abuse [48]. In a study of 3,157 older Chinese immigrants, 15% reported experiencing mistreatment by a family member [222]. In a separate study of 2,713 older Chinese Americans, the overall abuse rate was 8.8% [223]. In a study of Chinese women older than 60 years of age, 15.8% experienced mistreatment [224]. In each of these studies, poorer health status and/or deteriorating health were associated with mistreatment.

It is crucial to remember that the lack of research in this area does not imply that elder abuse does not exist in ethnic minority communities. Unfortunately, cross-cultural research in this area requires considerable funding to obtain adequate sample sizes, the development of culturally sensitive instruments, and the hiring and training of interviewers who can meet the tremendous diversity within the many ethnic minority groups.

DEFINITIONS OF ELDER ABUSE AND CONTROVERSIES

In general, elder abuse literature has identified three basic categories of abuse and neglect: domestic elder abuse; institutional abuse; and self-neglect or self-abuse. The World Health Organization (WHO) defines elder abuse as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person" [225]. However, one of the biggest difficulties in the field of family violence revolves around the definition of the problem. Defining social problems is controversial because the definition determines the prevalence rate of who is counted as abused and who is not. It determines what legislation does and does not cover, and it directs programs regarding the eligibility criteria of who does and does not receive services.

What constitutes elder abuse, mistreatment, and neglect? Must elder abuse include a component of trust between the victim and perpetrator [218]? Often, the terms "abuse," "mistreatment," and "neglect" are used interchangeably. Yet, the definition is extremely important, as it sets the stage for measurement in empirical studies, reporting of incidences by practitioners, and development of policies and programs. In some cases, "abuse in later life" is used interchangeably with "elder abuse," but the former term is usually specific to domestic violence or sexual abuse of an older adult. "Crimes against older adults" refers to burglary, financial scams, and/or theft of older individuals [218].

Abuse is generally perceived as more serious because it is viewed as a deliberate or intentional act to harm [10]. Conversely, neglect has generally been viewed as less serious because the intent of the perpetrator is not necessarily deliberate. That is, neglect is an act of omission—not doing something because of ignorance or some situational factor (such as stress) [10]. The Centers for Disease Control and Prevention, the NCEA, and other organizations include both an intentional act and a failure to act in their definitions of elder abuse [23; 49].

Other definitions have focused on the types and categories of abusive acts. The NCEA and the Administration on Aging have defined seven different types of elder abuse, which are based on state and federal definitions [49; 50; 218]:

- **Physical abuse**: Use of physical force that results in injury, pain, and impairment. Examples include slapping, punching, kicking, and restraining.
- **Sexual abuse**: Nonconsensual contact of any form.
- **Emotional abuse**: Infliction of distress, anguish, and/or pain through verbal or nonverbal acts.
- **Financial/material exploitation**: Illegal or improper use of the elder's resources, property, funds, and/or assets, without the consent of the elder.

- **Neglect**: Refusal or failure to provide goods or services to the elder, such as denying food or medical-related services.
- **Caregiver neglect/abandonment**: Desertion of an elderly person by the individual who has physical custody or who is the primary caretaker of the elderly person.
- **Self-neglect**: Behaviors of the elderly person that jeopardize his/her own safety and/or physical health.

The types of elder abuse in nursing homes, categorized as institutional abuse, include physical abuse, psychological abuse, neglect, and financial abuse as identified above [23]. Other forms of nursing home abuse include use of inappropriate restraints, substandard care, overcrowding, authoritarian practices, denying residents' daily activity choices, and labeling troublesome individuals, which results in depersonalized treatment [51]. In a qualitative study of elderly nursing home residents and staff in the Czech Republic, one of the recurrent themes was the violation of rights to make decisions and free choice [52]. Due to the restrictive environment in institutional settings, freedom to make decisions regarding activities of daily living becomes important. The lack of respect for elderly residents' dignity and privacy were also noted as dimensions of abuse in institutional settings.

Another form of elder abuse in nursing homes that has been the subject of limited research is nursing home theft. In a study of 47 nursing homes, 6% of the nursing home staff members reported witnessing colleagues stealing from elderly patients [53]. Another 19% suspected coworkers of stealing.

It is important to remember that these forms of abuse are not mutually exclusive. An older individual who experiences one type of abuse will often be the victim of another form of abuse as well. A study of 842 women 60 years of age and older found they often experienced multiple abuses [54]. For example, 69% of the women who had been abused physically also experienced psychological abuse or controlling abuse.

Overall, the definition and conceptualization of elder abuse has been fraught with challenges. Anetzberger offers an updated typology of elder abuse that may be used when assessing the components of abuse [55]:

- **Perpetrator**: Self, trusted other, or stranger or acquaintance
- **Setting**: Domestic or institutional
- **Form**: Neglect and/or abuse
- **Perpetrator motivation**: Intentional or unintentional
- **Locus of harm**: Physical, psychological, social, financial, and/or sexual

Some have gone a step further to suggest that self-neglect, self-abuse, and intimate partner violence should be included in the category of elder abuse [25; 235]. Analysis of existing elder abuse laws in the United States found that there is no single consensus definition of the concept; however, common terms included exploitation, neglect, abandonment, and sexual abuse (each of which was ambiguously defined in many cases) [19].

CASE STUDIES

Read each of the following case scenarios and try to determine what type of abuse was sustained.

Case Study 1

For several weeks, church members noticed that Mr. L, 82 years of age, had bruises, cuts, and scrapes on his face, hands, and arms. Mr. L always had some plausible explanation and, knowing that he was the sole caretaker for his very ill wife of 61 years, they did not press the issue. A hospital social worker finally contacted APS after Mr. L drove himself to the hospital emergency room, over 20 miles from his home, with multiple fractures to his left arm. The APS social worker eventually discovered that Mr. L was being attacked by his wife, who was suffering from undiagnosed Alzheimer disease and had become combative. Mr. L did not know that his wife's behavior was a part of her illness and was protecting her.

Case Study 2

Mrs. J, a long time insulin-dependent diabetic, was admitted to the hospital after being brought to her physician's office by a neighbor who became concerned after not seeing Mrs. J for several days. Mrs. J finally told hospital staff members that she had run out of insulin several days ago and had given her grandson all the money she had to go and refill her prescription. He did not return, and Mrs. J did not call family members because she did not want to get him in trouble.

Case Study 3

Mr. B, 74 years of age, complains with increasing frequency of pain. His physician is puzzled by the complaints because the methadone she has prescribed should be controlling the pain. She has already increased the dosage a couple of times and is reluctant to do so again. She finally asked a family member to bring in all of Mr. B's medications so that she could check for drug/drug interactions or perhaps prescribe another medication. Examination of the methadone tablets revealed that someone had switched most of the methadone with over-the-counter potassium tablets, which are nearly the same size and color. Mr. B's failing eyesight prevented him from being able to tell the difference between the very similar tablets. Questioning revealed that Mr. B's niece, a former drug addict, had been living with him in exchange for his care, and that she prepared his medications each day. The family suspected that she was using drugs again, but was reluctant to probe too deeply because there was no one else to care for Mr. B.

GENERAL PROFILE OF ELDER ABUSE VICTIMS

There are some studies that indicate that women are more likely than men to be victims of elder abuse [56]. Other demographic factors that contribute to risk include unmarried status and non-White ethnic origin [57]. Elders who reside with a caregiver or family with a history of substance abuse, mental illness, and violence are more at risk of abuse [56]. One study found that elders who have short-term memory problems, psychiatric diagnoses, and/or alcohol problems are more vulnerable to elder abuse [58]. Elders who have poor health and low income also appeared to be at risk of elder abuse [55; 57]. Many studies that have found a relationship between elder abuse and existing health problems, functional physical deficits, and frailty. Whether health status is measured with objective evaluations or via self-reports, an elderly individual with poor health is at an increased risk of elder abuse [254]. Certain personality traits are also associated with elder abuse. Those who score higher on measures of neuroticism have been found more likely to report elder abuse [255]. Neuroticism is a personality trait whereby one tends to experience negative emotions and greater emotional instability. These persons may be more reactive to conflicts and tend to focus on negative rather than positive events [255].

TYPOLOGY OF ABUSERS

Several different typologies have been suggested for abusers. In their 2017 study, DeLiema, Yonashiro-Cho, Gassoumis, Yon, and Conrad identified four different abuser categories [226]. The first category is "caregiver abusers," and as the name indicates, these are the individuals are responsible for the care of an older adult. These abusers provide the most support, but may lack sufficient caregiving knowledge and skills. The second category is "temperamental abusers." These persons are caregivers who have difficulty controlling their tempers. The third category is "dependent caregivers." These abusers have challenges maintaining a job and rely on the victim's financial support. The last classification is "dangerous abusers," because they exhibit high levels of aggression, substance abuse problems, and financial dependence on the victim.

Similarly, Ramsey-Klawsnik has formulated a classification or typology of perpetrators of elder abuse [59]. This typology provides a description of overall characteristics of abusers.

The Overwhelmed Offender

This is an individual who is responsible for providing day-to-day care for the elder, and the amount of caregiving that is needed exceeds the caregiver's ability. This type of offender realizes that his/her behaviors are abusive but has difficulty asking for or seeking help. This type of abuser is the most often depicted [55]. However, the caregiver stress theory does not completely explain elder abuse.

The Impaired Offender

This is an individual who has a physical or mental impairment that makes caregiving difficult. This type of offender tends to be neglectful, administer medications inappropriately, and use restraints. Impaired offenders often do not realize that their behaviors are abusive. Research seems to indicate that perpetrators of elder abuse tend to have substance abuse and mental health issues [55].

The Narcissistic Offender

This type of offender does not want to provide caregiving and is only doing so to exploit the elder. Oftentimes, the abuse involves neglect and financial abuse.

The Bullying Offender

This offender has little empathy or compassion for elders. Bullying offenders want to exert power and control over their victims. Their victims are too frightened to disclose the abuse and will merely attempt to placate the abuser. These offenders employ a range of abusive behaviors that includes physical, sexual, verbal, emotional, and financial.

The Sadistic Offender

This type of perpetrator enjoys humiliating and inflicting terror on the elder and experiences no guilt or remorse for abusive actions.

These different typologies do not necessarily contradict each other. Rather, they can be used supplementally to assist in developing targeted interventions for elder abuse perpetrators [226].

CONTROVERSIES IN THEORETICAL CONCEPTUALIZATION

How a social problem is conceptualized or defined greatly influences the perceptions of the problem, its attributes, etiology, and the policies and interventions. Although the social problem of elder abuse has existed for thousands of years, there has been an absence of a coherent theory. The field has borrowed and/or adapted many theories from other fields, including child abuse, intimate partner violence, and criminology [218]. Wolf identified six broad theoretical models to explain how practitioners and researchers have conceptualized why elder abuse occurs [60; 61]. Wolf's broad theoretical frameworks are:

- Situational model (i.e., the overburdened caregiver)
- The dependent victim and abuser
- The impaired abuser
- Social learning theory (i.e., childhood of abuse and neglect)
- Feminist theory (i.e., imbalance of power in male/female relationships)
- Political economic theory (i.e., macro structures and conditions that lead to violence and conflict)

Experts have identified four theoretical models that overlap with Wolf's frameworks: elderly dependency, learning violence, problems experienced by victim and/or elderly, and societal attitudes [256].

The Overburdened Caregiver

This overburdened caregiver perspective is perhaps the only theory specific to elder abuse [218]. It argues that elder abuse is caused by a family member who assumes the caregiver role and who is exhausted, stressed, and burdened with the caregiver tasks revolving around the elderly individual who has functional and/or cognitive impairments [10; 62].

In other words, there are external or situational stressors that precipitate the abuse. Because the locus of caring is shifting from institutions to the family, families are expected to provide care and support to impaired elders [10]. The caregiver stress theory is one of the most frequently cited to explain elder abuse. However, empirical findings suggest that stress and dependency do not explain or predict perpetrating elder abuse; they merely contribute to abuse [55]. To rely on the caregiver stress theory to predict elder abuse can inadvertently result in blaming the victim for "being difficult" or "recalcitrant" and minimize the perpetrator's accountability [63].

The pressures of caregiving are very real. Caregiver stress is caused when the demands of providing care for the elderly individual are perceived as exceeding available resources [64]. Caregiver burden comprises the range of physical, psychological, social, and financial strains or problems experienced by family members who have a family member with a chronic illness and who assume the primary caregiver role [65].

The literature has identified two types of caregiver burden or stress experienced: objective and subjective burden. Objective burden is characterized by tangible, external stressors. This includes providing physical care, financial stressors, employment, and overcrowding. Subjective burden is defined by the emotions that result from caregiver stresses [66]. In one study, the average length of caregiving was seven years [67]. Elders with dementia, for example, often require extensive assistance with bathing, feeding, and bladder and bowel incontinence [10].

Studies have shown that the severity of abuse often increases as elders' cognitive functioning level decreases [45]. Furthermore, family caregivers who have sufficient economic resources are less likely to report using some sort of abuse on the elder family member. Those who experience higher levels of caregiver burden are more likely to abuse their elder family member.

Typically, overburdened caregivers are female, middle age, and have families of their own. They provide much of the caregiving with minimal assistance from other family members. They have very little respite and are taxed with the responsibilities of caregiving and providing for their own families [68]. In in-depth interviews with 11 married and employed Japanese women who were caregiving for an elderly parent, researchers found that many of these women, despite their own career and professional aspirations, placed a higher priority of taking care of their elder family members due to deeply ingrained cultural beliefs about gender roles and filial piety [69]. The women initially took on the task of providing care to their elder parents or parents-in-law because this was the cultural norm. Over time, they felt oppressed as the caregiving duties became overwhelming. Their spouses often adhered to traditional beliefs that caregiving is a female responsibility. The multiple demands and strains these women experienced led to feelings of anger, loss of self-esteem, lack of self-worth, shame, and guilt. The majority of modern elder abuse prevention interventions (e.g., reducing caregiver stress) stem from this theory [218].

Case Scenario

Mr. R, 54 years of age, and Mrs. R, 49 years of age, work full time in very demanding jobs. About one year ago, Mr. and Mrs. R built an apartment addition onto their home, depleting their savings, to accommodate Mrs. R's mother, Mrs. D. Mrs. R is the oldest of three siblings and care for her aging mother had become primarily her responsibility. The 90-minute drive to her mother's apartment in a nearby city each weekend had become increasingly taxing, and her mother's care had become more time consuming. When Mrs. D's long-time physician announced his intent to leave private practice, it became reasonable to make the move. Mrs. D, while not enthusiastic, was agreeable. Mrs. R's brother and sister, who rarely visited or helped with her mother's growing needs, became angry about the move and stated that they had no intention of making such

a trip. Now, in addition to working 9 to 10 hours per day, Mrs. R goes home to find numerous messages from her mother with various requests and demands. Additionally, because her mother can see her car drive up, the phone is usually ringing by the time she gets into the house to begin dinner for the three of them. There is an in-home aide who comes three days per week to help with bathing and light cleaning, but lately Mrs. R has questioned whether this is worth the added burden of mediating disputes between the aide and her mother. Each morning before work, Mrs. R prepares her mother's medications for the day and makes sure she has something available for breakfast. She longs for a vacation, but the routine continues seven days per week. Besides, all her vacation and sick leave must be devoted to taking care of her mother's medical appointments and treatments. Lately, Mrs. R has been having difficulty sleeping with disturbing dreams of having forgotten some major task. She feels tired all of the time. She has also noticed that she snaps at her spouse and friends often and that her anxiety level is increasing. Her own household chores are piling up because she does not have the time or energy to do them. Last week she noticed a red rash on her thigh and wonders when she might find the time to see her own doctor.

Early theoretical models proposed that caregiver stress was a contributing factor to elder abuse; however, stress alone does not explain the phenomenon. Researchers tend now to look at stress in the wider context of the overall quality of the relationship between abused and abuser. The nature of the pre-abuse relationship between the caregiver and the care recipient may be an important predictor of future abuse [15; 70].

Dependency Theory

Early theories on elder abuse sought to associate dependency with increased risk of abuse [70]. This is based on Family Power-Dependent Relationship Model and social exchange theory. In the Family Power-Dependent Relationship Model, the child caregiver perceives that there is a reduction of power because the elder has become more frail and dependent. By using aggression, The caregiver uses aggression to claim more power [218]. Similarly, social exchange theory posits that the interaction between two or more persons will be positively evaluated if all persons involved benefit equally from the relationship [36; 218; 256]. An imbalance or unequal exchange in the relationship will be viewed negatively, and this imbalance will result in abuse. Initially, the focus of research was on the increasing dependency of the elder victim on the caregiver or abuser, often an adult child [36; 70]. The increasing cost to the caregiver of providing emotional, economic, and physical care to the elderly parent without the positive mutual exchange in the relationship might be viewed as unfair to the caretaker, leading to relationship imbalance and increased risk of elder abuse [36]. Interestingly, Baumann argued that the picture of the frail, weak, and dependent elderly made it easy to call national attention to elder abuse and to justify allocating resources to this social problem [13]. However, Pillemer argues that there is no empirical evidence that elder dependency causes elder abuse [71]. In fact, elder abuse only occurs in a small percentage of the elderly population, and in a study of patients with Alzheimer disease, only 5% of the caregivers became abusive [72]. In addition, Pillemer and Wolf maintain that the problem with this perspective is that it rests on an ageist assumption that all people automatically become dependent and powerless as they age [73]. Thus, they assert that the dependency may lie elsewhere.

Later case work identified abusers who were dependent on the older person (e.g., an adult child dependent on an elderly parent for housing or financial assistance) [70; 254]. Because of the sense of imbalance in the relationship and the violation of social expectations regarding independent adult behaviors, the perpetrator attempts to restore some sense of control by using violence [36]. However, some have a critical view of exchange theory, arguing that to use exchange theory for elder abuse "reproduces assumptions of market economics, independence, and value in the present that reproduce instrumental attitudes to relationships rather than focusing on altruism and life-course interdependence" [74]. However, Wolf and Pillemer found that in many instances of elder abuse, a large number of abusers were financially and emotionally dependent on the elder [75]. In some instances, a "web of interdependency"—a strong emotional attachment between the abused and the abuser—made intervention efforts difficult [70]. Some experts have reported on a "tacit exchange," whereby the elderly individually tacitly accepts the abuse in order to obtain care and companionship. Furthermore, victims may be fearful of being removed from their current living situation to a nursing home [257]. To date, no interventions have been developed based on this theory [218].

This dependency is illustrated in the following vignette.

Case Scenario

Mr. J had returned to live with his mother, Mrs. J, a widow of ten years, after his wife insisted he leave their house. During this time, he became depressed and started to drink. Mrs. J's neighbors became concerned that Mrs. J had lost a tremendous amount of weight and looked sad and disheveled lately. One day, Mrs. J confided to one of her neighbors that ever since her son returned to live with her, he had been pilfering her Social Security checks. Initially, she noticed that small amounts of money were missing from her pocketbook, but now, Mr. J threatens her both verbally and physically. He would smash and throw china at her until Mrs. J handed her signed Social Security check to him.

The Impaired Abuser

The focus of this theory is on the abuser's behavioral characteristics; however, there is minimal research evaluating this theory, as it is difficult to conduct research with elder abuse perpetrators [58]. Substance abuse and psychiatric illnesses are risk factors for elder abuse. In one study of the relationship between reported instances of elder abuse and regional levels of substance abuse, researchers found that elder abuse was related to higher rates of illicit drug use in the past month by either the victim or the perpetrator [76].

The Abuser was Abused/Neglected When Young

The social learning theory argues that individuals' learning patterns occur through observations of others [77]. When applied to the area of family violence, some researchers have coined the term "intergenerational transmission of violence," which maintains that abusive behaviors are learned. The intergenerational transmission theory argues that the dynamics of abusive behavior get perpetuated, and this is the reason why some abused children become abusers themselves [3; 218]. A study conducted by Hotaling et al. found that abused children are more likely to exhibit aggressive behavior toward family members and to engage in crime outside the family [78]. The intergenerational theory is very popular and makes intuitive sense; however, empirical research does not indicate that abusers of the elderly are more likely to have been raised in families that were violent [36].

Feminist Theory

Feminist theorists argue that violence against women is broadly defined as male coercion of women [79]. In other words, patriarchy and male domination contribute to violence against women [80; 81]. Patriarchy is perpetuated and reinforced by cultural ideologies, existing social institutions, gender socialization, and socioeconomic inequalities [80; 81]. Thus, the root of violence against women stems from power imbalances in male/female relationships and male domination in the family, which is reinforced through current economic structures, social institutions, and the sexist division of labor [81].

Some argue that feminist theory is not useful to addressing elder abuse, because it does not necessarily explain the different types of elder abuse or the typologies of abusers [218]. However, feminist theory has relevance to elder abuse because elderly abused women are often not thought of as battered women or domestic violence victims. In other words, we do not think of elderly women being abused by their spouses. Studies on domestic violence, for example, have typically excluded women older than 59 years of age [82]. Vinton argues that service providers and scholars have traditionally dichotomized the terms "battered women" and "elder abuse victims" [12]. Each of these terms conjures up images for us; for example, rarely do we associate a battered woman or domestic violence victim with an elderly woman. Instead, we might use the label "elder abuse" because we have inscribed in us a mental picture of an elder abuse victim as a frail elderly person being abused by a caretaker. However, domestic violence does occur throughout a woman's lifespan [83]. Band-Winterstein and Eisikovits argue that intimate partner or domestic violence does not necessarily "age out" and that this notion is a myth [84]. In a study of 620 middle-aged and older women recruited from emergency rooms in an urban setting, 5.5% had experienced intimate partner violence within the last 2 years [85]. Forms of abuse included sexual abuse and verbal threats or use of physical force to make them have sex. It may be that abuse among older couples can be better understood by the abuser-victim dynamics of the domestic violence model than the elder abuse model, which is based on the concept of caregiver stress [86; 87]. For example, older women's inability to leave an abusive marital relationship is very similar to their younger female counterparts, such as fear of reprisal [82]. However, for older women, concerns of finances and economic resources stem from their ability to obtain a job, lack of pension, and health and physical limitations [84].

This type of dichotomous thinking has implications for interventions. On one hand, a battered woman will be referred to a shelter, and an elderly female victim of abuse will be referred to Adult Protective Services [88]. In part, this dichotomous conceptualization has been shaped by the historical legacy of the domestic violence and elder abuse movements. Domestic violence, or the battered women's movement, emerged in the late 1960s when second-wave feminism and social activism were active. Then, in the mid-1980s, elder abuse emerged as a separate, distinct social problem and was primarily depicted as a social problem where the perpetrators were caretakers.

Political Economic Theory

This theoretical perspective maintains that American societal norms and attitudes may contribute to elder abuse. First, negative attitudes about the elderly create an atmosphere that breeds elder abuse [10; 258]. Ageism is defined as "any attitude, action, or institutional structure that subordinates a person or group because of age or any assignment of roles in society purely on the basis of age" [89]. Our stereotypical views of the elderly include images of elders losing their memory, being less flexible and resilient, and being grouchy and unproductive. Although there is no empirical research that directly links ageism to elder abuse, the argument is that these stereotypes and myths play a role in dehumanizing elders. The process of devaluing and dehumanizing a particular group lends to and perhaps even provides justification for certain discriminatory and/or abusive behaviors [90]. Ageism promotes apathy towards the treatment of elders, and consequently, social problems, including elder abuse and neglect, do not receive the same attention as other problems [10; 90].

Disengagement Theory

Disengagement theory was proposed by social scientists in 1961 and was the first social science theory of aging. It describes a process of disengagement from social life that people experience as they age.

The theory states that, over time, elderly people withdraw from the social roles and relationships that were central to their life in adulthood. This process is deemed necessary and beneficial to maintaining societal stability and order [91]. The theory caused controversy as soon as it was published. Opponents argued that it ignored many aspects of aging and that it failed to capture the complex and rich social lives of the elderly and the many forms of engagement that follow retirement. The authors of one paper developed a profile of the social integration of older adults that included nine dimensions of connectedness [92]. Using data from the National Social Life, Health, and Aging Project (NSHAP), they conducted a population-based study in 2005–2006 of noninstitutionalized Americans 57 to 85 years of age. Their findings suggested that age was negatively related to network size and closeness to network members but positively related to frequency of socializing, religious participation, and volunteering. The authors concluded that late life transitions (e.g., retirement, bereavement) may prompt greater connectedness.

CULTURE, RACE, AND ETHNICITY AND ELDER ABUSE

Why is it necessary to put on a cultural lens when we talk about elder abuse? First, the United States is becoming increasingly diverse in terms of ethnic composition. According to U.S. Census data, there were 43 million foreign-born individuals in the United States in 2017 [93]. The majority (51.2%) are from Latin America (including the Caribbean, South America, and Central America) [93]. Three states—California (10.7 million), Texas (4.9 million), and New York (4.5 million)—have the largest immigrant populations in the United States [259]. By the 2040s, the United States is expected to become a majority-minority country, with estimates that 49.7% of the U.S. population will identify as White by 2045 [260; 261]. As a result, it is inevitable that race, culture, and ethnicity will have a profound effect on how we think, feel, and act. Race, culture, and ethnicity become the lens through which we view the world and touch on all aspects of human life [95]. Consequently, practitioners will need to become more culturally aware and sensitive to the cultural norms, belief systems, and needs of culturally diverse patients in order to provide culturally relevant services and interventions. In other words, it is inevitable that we talk about cultural competency. Cross-cultural competency is defined as a dynamic attribute that professionals develop in the areas of attitude, knowledge and skills to work with an increasingly multi-ethnic and diverse society [95]. Ultimately, the goal of cultural competence is to reduce the differences between the belief systems of clients and patients from diverse cultural groups and the institutional cultural norms of service delivery agents. This will then mitigate the disparities that exist in the current mental health and healthcare systems [96].

Second, cultural values and belief systems influence norms about family life and structure. It is vital to examine various ethnic groups' norms of family life, as every family system shapes and guides rules, obligations, roles, and labor divisions [97]. Because one's family of origin is the foundational building block to socialization, understanding general views about gender roles, beliefs about family authority, and views about elderly family members will assist us in understanding the intersection of culture, race, and ethnicity and family norms on elder abuse.

A third reason to take into account culture, race, and ethnicity in the study of elder abuse is that these factors influence the labeling or the perception of the social problem. Diller argues that human beings relate to their world through cognitive worldviews or paradigms [98]. These worldviews and paradigms provide individuals with rules and assumptions about how the world works. Culture and ethnicity provide the content of these worldviews [98]. Consequently, how a group labels or constructs abuse or maltreatment is influenced by their cultural beliefs and values, which ultimately affect how domestic violence is perceived, exhibited, and reported [99].

Furthermore, the social realities of the lives of older abused immigrant women may be uniquely different from their younger counterparts as a result of generation, acculturation, and gender role socialization differences. These factors may distinguish how elder abuse victims label their situations and what services they may seek [100].

Fourth, it has been postulated that certain ethnic minority groups may be more vulnerable to violence because of the existence of environmental risk factors such as poverty, racism, oppression, and discrimination. For example, the sociocultural backdrop of slavery, oppression, and economic deprivation may have contributed to any violent behavior seen in the African American community [101]. For Native American Indians, experiences with historical trauma have been implicated with victimization in all forms of abuse, including elder abuse [262].

Finally, culture, race, and ethnicity influence help-seeking patterns. There are a host of factors that influence ethnic minority families and elders in seeking outside professional assistance. This might include financial limitations, suspiciousness or wariness of professionals, or inconvenience in locating and traveling to agencies [102]. However, help-seeking behavior is in part influenced by the individual's definition and understanding of the phenomenon, which is ultimately influenced by culture. For example, an ethnic minority elder who is being abused by another family caretaker may not seek help because he/she does not label the event as a problem. Instead, the victim believes that the event must be something that should be persevered. In other words, the victim shares a "cognitive map" or explanatory model about the explanations and expectations regarding illness, symptoms, or other events like violence [102].

Despite these benefits, it is important to be careful not to overemphasize the role of cultural differences or to inadvertently attribute deficits or adverse outcomes to cultural practices [227]. There are often other contextual factors that should be factored into understanding elder abuse.

CULTURAL NORMS AND VALUES REGARDING FAMILY AND THE ELDERLY

This section will briefly review cultural values and norms about family structure and views about the elderly within each of the four ethnic groups: African Americans, Asian Americans, Hispanics/Latinos, and Native Americans. It is crucial that, as helping professionals, we understand cultural values because they are the driving forces guiding daily behavior [103]. Cultural norms about family life and the role of elderly family members will have an impact on how the elderly are treated within society and the family and, ultimately, how elder abuse is perceived.

It is important to remember that there is tremendous diversity within groups. In other words, factors such as acculturation, age at immigration, education level, socioeconomic status, and religion all contribute to the heterogeneity within each subgroup. Falicov cautions against static descriptions of ethnic groups because they are merely social science simplifications rather than true portraits of the complexities of culture, race, and ethnicity [104]. Consequently, bear in mind that the following information is intended to present general themes to guide practice and not indicate hard and fast rules.

African Americans: Family and Elders

According to the U.S. Census, African Americans constitute 14.7% of the U.S. population as of 2019, numbering 48.2 million [263]. By 2060, it is projected they will comprise 17.9% of the U.S. population.

The family is very important in African American history, and values related to the family are rooted in African traditions. It has been said that the African American family structure is what enabled African Americans to survive during slavery and the challenging times of the Jim Crow era [106; 229].

Terms such as "my family," "my folks," and "my kin" refer to both blood relatives and those who are not related, such as special friends and cared for individuals [5]. This was confirmed in a qualitative study in which African American family therapists discussed the roles of African American families' strengths in therapy [107]. The therapists all identified the strong kinship bonds that existed in African American families and noted these bonds extended beyond nuclear family members into extended family members and into the community. Similarly, marriage is viewed among African Americans as a "sacred vow" and covenant [106]. During the slavery period, when family life was severely disrupted, kinship bonds were highly relied on for support. Young children of slaves, for example, were often cared for by older women or children [5]. Parents attempted to discipline and raise their children to the best of their ability given the constraints of life in slavery.

Extended family networks are common in African American families. Many African American family structures are multigenerational and interdependent. In a study conducted by Martin and Martin, it was found that an extended family network might consist of five or more households centered around a base unit, where the "family leader" resides [108]. This extended family network system pools resources to help during hard times. These strong kinship networks are the key element in helping African American families cope with economic stressors as well as structural issues such as racism, oppression, and discrimination [108]. Similarly, Goode notes that the value of group effort for the common interest is highly valued [5]. There is an expectation that one shares with the larger African American community, and this value orientation is part of that strategy for survival. Simultaneously, the value of independence is emphasized, which focuses on the ability to stand on one's own feet and to have one's own focus [5]. It revolves around the ability to earn a living, care for one's family and provide for them, and have some left over to help others in the extended family [5]. Jackson observed that African American families have demonstrated an elastic quality, assuming flexible roles to adapt to change and stress [109]. Family therapists have noted the amazing resilience and creativity of African American family members in utilizing internal and external resources in handling the challenges that emerge [107]. Economic reasons are not the only reasons why African Americans share households. They also adhere to cultural beliefs about closeness and connectedness [110].

The elderly are highly valued in African American families [229]. Dating back to Western African traditions, the provision of care of elders is embedded in the belief that it is the responsibility of the kin group and care is a collective process [111]. Even during slavery, slave communities provided care to elderly slaves who could no longer work. Although times and the structure of families have changed, many African American families still abide by these cultural norms. African Americans have the lowest utilization rates of nursing homes; tasks of caregiving in African American families are often spread out to different family members rather than having one identified primary caregiver assuming all responsibilities [111].

Elders are viewed as the repository of wisdom and hindsight, termed "elder educators" [5; 112]. In traditional African religions, the oldest family members are believed to have special status and an ability to communicate with God [5]. Harper and Alexander note an interesting and unique trend about African American elders [113]. African American elders tend to live in multigenerational households; however, they do not go to live with their children. Rather, it is their children who move in with them. For example, daughters who are divorced, widowed, or separated commonly return with their children to live with their parents [113]. It is very common for grandmothers to help in rearing the children of single mothers [114].

Asian Americans: Family and Elders

In the 1990s, the number of Asian Americans in the United States increased tremendously due to high levels of immigration from Asian countries. In 2019, 22.9 million Americans identified solely as Asian [264]. It is projected that this number will reach 41 million by the year 2050, which would be 9% of the total population [94]. More than half (58%) were foreign-born in 2005, but by 2050, fewer than half (47%) will be foreign-born [94].

Approximately one-third (31%) reside in California; however, a greater dispersion of Asian Americans to other states has begun. This trend reflects the refugee groups that immigrated during the 1980s and the 1990s and more recent immigrants from India and Pakistan [116].

Generally, traditional Asian families can be characterized as hierarchical. In other words, family authority and structure is defined by family position, which is determined by age and gender [117]. Older family members have higher status than the young, and men hold higher positions than women [117]. Family harmony and equilibrium are valued, and one way to maintain this balance is to adhere to the hierarchical structure. In addition, traditional Asian American families are patriarchal in nature; the father maintains authority, and the sons are more desired and valued because they symbolically carry on the family line and care for their parents when they become old [117].

Mutual support, cooperation, and interdependence also characterize the family [118]. As a result of the close-knit nature of Asian American families, there is a strong sense of obligation and duty to others [119]. Problems are generally solved within the family, and a sense of family honor and pride limits outside information to be shared by counselors or other professionals [118].

The term "family" can be defined in multiple ways in the Asian American community and can include a wide network of kinship. In many Filipino families, for example, trusted friends serve as godparents to children and play a vital role in their socialization process [119].

Elders are generally venerated in Asia. China, for example, has been described as a gerontocracy because of the overall attitude of respect and veneration toward the elderly [120]. Filial piety refers to a series of obligations of the child to the parent for providing emotional and economic support and bringing honor to the parent by doing well educationally and occupationally. These obligations are dictated by Confucian values and have governed many generations of Asian families [121]. In India, children are socialized early to respect elders as an intricate part of the family system [122]. Unlike American society, which encourages independence to maintain self-esteem, Asian elders encourage their children to operate under a framework of mutual dependency [123]. Old age signifies wisdom, status, and power in the traditional Asian family system [124].

Due to westernization and modernization, many Asian countries are experiencing rapid shifts in cultural norms. It is speculated that in countries that have moved toward more capitalistic and market-driven economies, the values of family and collectivism have shifted more to individualism. These changing social norms may have impacted the family structure and how families care for their elders [125]. For example, in Japan, more women have returned to the work force, perhaps due to the economic recession as well as shifts in gender role perceptions [125]. Some have noted that traditional and modern cultural beliefs are becoming more fused, including beliefs regarding filial piety [126]. In focus groups with Taiwanese university students, students' beliefs of filial obligation were found to be deeply rooted in their belief systems; they believed that it was their duty to care for their parents [126].

The participants acknowledged the deeply rooted traditions of filial piety that were passed down in their families. However, for some of the students, filial piety was not necessarily demonstrated by living with their parents. They argued by not living with their parents, they would have a greater chance of achieving intergenerational harmony. Furthermore, they stated it was not completely clear how they will actually practice the day-to-day dimensions of filial piety as circumstances are never constant. Therefore, filial piety is dependent on circumstances [126; 231].

Loneliness and social isolation experienced by elders have been identified to be predictors of elder abuse. This might be more salient with ethnic minority elderly immigrants. In one study, the researchers found high rates of loneliness, ranging from 24% to 50%, among elder immigrants from China, Africa, the Caribbean, Bangladesh, and Pakistan [127]. Kao and Lam maintain that when Asian immigrants age in the United States, what they experience is very different from how they were socialized [123]. It is a more demanding task to age in a society where their contributions are devalued, compared to a society where elders are treated with deference. This is demonstrated by the fact that loneliness is a significant predictor to elder abuse. In a survey study of 410 elderly Chinese patients (60 years of age and older), elders with higher reported levels of loneliness were four times as likely to experience elder mistreatment compared to elders with lower scores [128]. It is possible the rapid industrial changes in China have created tension between the older and younger generations in their prescriptions of familial responsibilities and roles.

Hispanic/Latinos: Family and Elders

The Hispanic/Latino population is also a very diverse ethnic group. They hail from Mexico, Puerto Rico, Cuba, and Central and South America. Ramirez has observed that mestizaje contributes to these complex within-group differences [129]. *Mestizo* refers to the genetic mixture that evolved from amalgamation due to European colonization and the intermingling that occurred between the European population and the indigenous people of the Americas as well as within the various indigenous tribes [129]. The term "Latino" is the preferred term as one that is self-applied, and the term "Hispanic" is a category used by the U.S. Census [103]. Latino describes people whose ancestors come from the Spanish-speaking countries of Latin America as well as those of Spanish and Indian descent whose ancestors have always lived in areas of the Southwest United States, which was once part of Mexico [130]. The word Latino describes diverse ethnic cultural groups, not a singular religious or racial group. Latinos engage in a variety of religious and spiritual practices, and may be White, Black, Indian, or Asian. Latinos most often identify themselves by their national origin, for instance, as Dominicans or Mexicans. According to the U.S. Census, 63.4% Hispanic Americans originated from Mexico in 2015 [131].

Hispanics are the largest minority group in the United States, numbering 60.6 million in 2019 [265]. It is estimated that the Latino/Hispanic population will increase to 128 million by the year 2050 [94]. In 2019, the three states with the largest Hispanic population (California, Texas, and Florida) also had the most growth [266].

The family is of paramount value, which is influenced by both the Spaniards' Catholic religion as well as the values stemming from the indigenous people of the Americas [103]. In Hispanic culture, *familismo*, defined as putting the needs of the family before those of the individual, is a paramount cultural value [133; 234]. The emphasis is on family reciprocity, including financial support, shared day-to-day activities and child rearing, and support related to the challenges of immigration [134].

It is both matrilineal and patrilineal, as there was a mixture of both matrilineal and patrilineal tribal governances among the indigenous people of the Americas [103]. However, in traditional Puerto Rican culture, there is a hierarchy of authority based on gender and age. Men and older family members are ascribed authority [135]. Similarly, patriarchal gender roles exist among many Mexican American families [104]. These differences reinforce the notion that there is tremendous heterogeneity within this ethnic group.

The family is an extended system that includes blood relations, those related by marriage, and fictive kin adopted through *compadrazgo* [136]. *Compadres* (i.e., godparents or co-parents) and extended family have very strong and close relationships with family members, providing financial and emotional support [137]. *Padrinos* is the relationship between godparents and godchildren [135]. It is not uncommon to transfer children from one family to another during times of hardship and crises, and mutual help, protection, and caregiving are provided [136].

Community is another value that is emphasized. Unlike individualism, which is the hallmark of many of the values in the United States, Hispanics/Latinos focus on the collective, which extends to valuing community life [103]. Consequently, fictive kinship is a part of the fabric of life. Stemming from this value of community is the emphasis of the value of cooperation versus competition. Latino families teach children the importance of sharing resources [103].

In the Hispanic/Latino culture, self-sufficiency is not expected for the elderly [138]. Because of the values of respect, cooperation, and family, elders expect to receive emotional assistance from their children. Elders are believed to be the storehouse of tradition, wisdom, and tradition [139]. They are viewed as advisors and it is not uncommon for family members to seek the advice of elders for parenting, childrearing, and other aspects of family life. Children are obligated to provide care and to respect their elderly parents [104]. They play important roles when they live with their adult children. Hispanic elders' attitudes about old age and well-being were contingent on their interactions and their sense of connectedness within the family unit [139]. This is one reason threatening to send elderly parents to a nursing home is perceived as a form of abuse in some Hispanic families [234]. Hispanic immigrant parents view these cultural values as important as they strive to teach their children the importance of respecting the elderly and addressing elders with the proper titles. Some lament the challenge of instilling these values to their children as they become Americanized [140].

Native Americans: Family and Elders

Native Americans, or American Indians, like other minority groups, encompass people with many different languages, religions, organizations, and relationships with the U.S. government [141]. They identify themselves as belonging to a specific tribe, each with unique customs and values. Again, readers are cautioned to regard the themes highlighted below merely as general cultural themes and to keep in mind the tremendous diversity within the Native American population.

As of 2019, the Native American population numbered 6.9 million, or approximately 2.0% of the U.S. population [267]. It is projected that by 2060, this number will increase to 10.2 million, 2.4% of the total population [143]. As of 2022, in the United States, there are 574 federally recognized tribes and 324 federally recognized reservations [267].

In 2019, this group was more likely to live in Arizona, California, Texas, or Oklahoma [143]. The largest tribes are the Cherokee and Navajo. They are also a younger group, with a median age of 30.2 years compared to the median of 37.8 years for non-Hispanic White persons [143]. In 2019, this group had a poverty rate of 20.3%, compared with 9% among non-Hispanic White individuals [268].

The family is regarded as the cornerstone for emotional, social, and economic well-being for individuals [144]. The composition of the family is very different from the dominant Anglo culture in the United States. For some tribes, the term "family" goes beyond the nuclear family and includes everyone in the tribe or clan. The terms "brother" and "sister" are used to refer to cousins in Native American families [145]. Therefore, family members encompass both blood relatives and tribe members with no distinctions, which is consistent with cultural values that emphasize interconnectedness and harmony [146].

The primary relationship is not necessarily with the parents, but instead with the grandparents, who assume the caregiver and disciplinarian role [141].

For example, among the Native Americans from the Navajo tribe, it is common for grandchildren to be sent to live with their grandparents, which benefits both the child (by ensuring that care and traditional values are passed down to the younger generation) and the elder (by ensuring a means to provide assistance to older individuals) [147]. In addition, the term "grandparent" is not limited to the dominant culture's role of a grandparent, but instead grandparents for Native Americans can also include other relations, such as aunts, great aunts, and godparents. Similarly, parental roles are assumed not only by the biologic parents but also by siblings of the parents [141].

Elderly family members are highly regarded. The aged are believed to be the repository of wisdom, and their role is to teach the young the traditions, customs, legends, and myths of the tribe [148; 236]. In addition, the view of reciprocity is woven into the inter-relationships between elders and the young. Typically, elders help raise children, and caring for the elderly is considered "returning the favor" [149]. Consequently, in their old age they are taken care of by the tribe. This family orientation is reinforced by the cultural value of collectivism; that is, the value of being part of a group. Joe and Malach note that consensus is often the goal, and in decision-making processes, individuals often spend a lot of time trying to achieve consensus and harmony [150].

ROLE OF CULTURE, RACE, AND ETHNICITY IN ELDER ABUSE

Definitions and Perceptions of Elder Abuse

There has been a growing interest in the perceptions of elder abuse among ethnic minority populations. This reflects a recognition that culture, race, and ethnicity can influence what constitutes elder abuse, particularly because definitions of elder abuse reflect a White, middle-class perspective [151]. In addition, as noted previously, there is controversy about the definition of elder abuse and how to view the etiology of the problem.

Some studies employ cross comparisons among ethnic groups to identify similarities and differences regarding definitions of elder abuse. In a study that included African Americans, Korean Americans, and White elderly women, the participants were presented with scenarios of potentially abusive situations [152]. These scenarios included thirteen situations that covered various dimensions of elder abuse and mistreatment, such as physical, psychological, verbal, sexual, medical, and financial abuse and neglect [152]. They found that the Korean elderly women were more tolerant of potentially abusive situations compared to the other two groups. In other words, Korean elderly women perceived fewer of the situations (50%) to be elder abuse as compared to White elderly women (who perceived 67% to be abusive) and African American elderly women (73%). It is plausible that the Korean elderly women were more sensitive to hierarchy and traditional gender roles as espoused by traditional Korean culture. There are rigid role differentiations between husband, wife, and children in Korean culture; males are valued, and, therefore, hierarchy and patriarchy are emphasized in Korea [153]. These values affect the Korean elderly women's beliefs about what is acceptable behavior and what is not.

These findings were replicated in a study conducted by Moon and Benton [151]. The study consisted of 100 African Americans, 95 Korean Americans, and 90 White elderly individuals 60 years of age or older, all living in Southern California. All participants were interviewed face-to-face. In general, the majority of the participants, regardless of ethnicity, disapproved of obvious, blatant forms of physical abuse, such as hitting an elder. Interestingly, some participants stated that it might be tolerated depending upon the circumstances. For example, 9.5% of the Koreans, 5.6% of the White Americans, and 2% of the African Americans indicated that it was acceptable to restrain an elderly parent in bed depending upon the circumstances. In addition, findings indicated that the Korean Americans and African Americans were more willing to tolerate medical mistreatment of elderly individuals. When asked about the causes of elder abuse, Korean Americans demonstrated a significantly different

perception than either White or African Americans. Korean Americans, for example, felt that elder abuse was primarily perpetrated by those with a mental illness or problems with substance abuse.

In a study comparing elders living in Korea and Korean immigrant elders in the United States, 90% of both groups agreed that scenarios that depicted physical and financial abuse were mistreatment. However, there was a lower percentage of agreement (37% to 40%) regarding the scenarios that portrayed neglect [154]. Both groups were more likely to seek help in cases of elder abuse, though the likelihood was lower for cases of neglect. However, Korean immigrants were 17 times more likely to seek help in cases of physical abuse compared to their Korean counterparts. Furthermore, women and more educated individuals were more willing to seek help [154]. In one study, older Korean immigrants were less likely to perceive psychological or emotional abuse as elder abuse [221]. For example, silent treatment and name calling were not perceived as elder abuse.

In a Chinese study, elders were recruited for focus groups to discuss their perceptions of elder abuse [269]. Most of the debate about what constituted abuse was centered around intentionality. Some felt that if an unintentional behavior caused distress to a parent, it should be considered abuse. Because of Chinese tension between traditional cultural norms of filial piety and children's more Western acculturated views of independence and family, parents may view their children not spending time with them or not being attentive to their well-being as being neglectful [269]. In another similar study, four groups were recruited—Whites, African Americans, Puerto Ricans, and Japanese Americans—for focus groups [99]. In general, the Puerto Rican respondents were more likely to label a situation as elder abuse without qualification, and the White and Japanese American focus group participants were least likely to label a situation as elder abuse. Meanwhile, African Americans tended to look at the context or circumstances to assist in understanding whether a situation was considered abusive or not. They were also asked what was "the worst thing that a family member can do to an elderly person." The White focus group participants stated psychological neglect was the worst thing, the Japanese Americans listed psychological abuse, and African Americans stated psychological abuse and exploitation. Although most studies report differences among ethnic groups about the definitions and perceptions of elder abuse, it is not always clear how cultural values and norms play a role in these differences. Therefore, the specific cultural context can influence definitions.

Modernization in India has negatively impacted the social status of the elderly. Along with modernization come shifts in power structures and dynamics in the family system [155]. Like many other Asian cultures, Asian Indian elders are highly respected, as age is a valued social status [155]. Cultural norms about the treatment of elders can influence definitions. A quantitative study with older adults in India found that 52% stated they experienced disrespect as a form of elder abuse; this is not generally accepted as a form of abuse in U.S. laws and research [270]. Using a series of research methodologies to collect data about elder abuse within an Asian Indian context, some interesting results emerged. First, the cultural context does influence perceptions and definitions of elder abuse. Psychological/emotional abuse goes beyond insults, criticisms, and pejorative statements. In the Indian context, elders perceive behaviors that go against their religious or philosophical beliefs as constituting psychological abuse. For example, many Hindus have day-to-day dietary restrictions, and when elders live with their children who do not observe the same dietary restrictions, the elders may change their lifestyle to the extent that they perceive it as abuse or neglect. In a study focusing on Tamil and Punjabi immigrants in Canada, daughters-in-law were often identified as perpetrators of elder abuse in multigenerational households [156]. Nagpaul describes an elderly Indian woman who has stopped eating in the family kitchen because her daughter-in-law uses the same utensils to cook meat as in her vegetarian dishes. She now survives on bananas. She feels she has no other residential living options than to live with her son and daughter-in-law [155].

Financial exploitation may also fail to be viewed as abusive. In many cases, cultural norms may influence definitions and perceptions of financial elder abuse [237]. Behaviors such as family members taking small amounts of money from an elder, taking advantage of an elder for housing, or pressuring an older family member to provide excessive or inappropriate childcare may be common but not necessarily viewed as abusive. Financial abuse was further categorized by Chinese American elders in focus groups [271]. The first type of financial exploitation involved the perpetrator taking the elders' money, property, and/or resources without their permission or against their will. The second type was financial neglect, whereby the elder is experiencing financial hardship in getting their basic needs met but their adult children do not help [271]. All of the focus group participants saw these behaviors as breaking the values of filial piety.

Elder Abuse and Cultural and Social Contexts

While examining cross-cultural differences can be helpful in highlighting the differences and similarities between groups, some researchers have focused on studying one group in order to understand specifically how the qualitative details of their social realities might influence perceptions of elder abuse [157]. Again, because the sample sizes in such studies are frequently small, it is important to be cautious about generalizing findings to entire populations.

Using a review of the literature and the author's research with African Americans in North Carolina, Griffin noted that the generally accepted definition of elder abuse and the common profile of elder abuse victims and perpetrators may not necessarily apply for African Americans [157]. The general profile developed by Kosberg describes an elder abuse victim as older than 75 years of age, middle-class, widowed, White, and female, with mental or physical disabilities [158]. The perpetrator is described as a caregiver, typically a middle-aged adult woman who resides in the home of the elder.

Griffin argues that elder maltreatment and abuse in African American communities takes place in a markedly different social context [157]. As previously noted, African American elderly individuals frequently live in multigenerational family households, and unlike White elders who leave their homes and live with their children, children come live with them [157]. This situation provides a unique set of stressors that may contribute to elder abuse and maltreatment in this community.

Much has been written and speculated about the culture of violence in African American communities and whether this plays a role in risk factors for elder abuse among this group. Some suggest that historical violence against African Americans, perpetrated by individuals as well as institutions, is partially responsible for violent behavior among African Americans [159]. In a qualitative study of 30 older African American women, some women mentioned the spill-over effect of violence in the streets into the home as a trigger to family violence [160]. However, these arguments are not conclusive. Some have noted that the family structure of African Americans (that is, multigenerational households) can place elders at risk in their homes [101]. As described previously, adult children, as well as grandchildren and other relatives, are more likely to move into an elder's home. The strength of such multigenerational households is that it has allowed generations of poor African American families to pool their resources during hardships [159]. It can be argued that support from multigenerational living arrangements as well as from the church can be protective factors to elder abuse. However, Benton argues that the circumstances that contribute to relatives moving into an elder's home are typically due to stressors such as divorce, unemployment, or drug problems, all of which are risk factors for elder abuse [159].

The social or economic contexts also play a role in elder abuse among Native Americans. Dependency has become a variable studied in the field of elder abuse. Interestingly, in the mainstream literature on elder abuse, the research focuses on the elder becoming dependent on family members, which is believed to play a role in elder abuse. Boudreau observed that the direction of financial dependency is opposite for Native Americans; many young Native Americans are dependent upon their elderly family relatives for financial support [36]. Many elderly receive monthly paychecks from pensions, Social Security, or welfare, and because of the high rates of unemployment, many younger Native American adults rely on their elderly family members' funds [161]. Consequently, many Native American elders are at risk of financial abuse [238]. The economic stressors on many Indian reservations have also adversely impacted the family kinship system. Many have had to leave the reservations in order to find employment, leaving elders behind. Some service providers have asserted that this leaves elderly family members isolated, without family to provide for the care they might need [161]. Furthermore, years of social and historical forces that reinforce racism (e.g., failure to recognize tribal groups, relocations, forcible removal of children to boarding schools, and exploitation of Indian land) have negatively impacted the traditional Native American family system. Family ties and traditional values that emphasize the collective unit have both been disrupted [162].

Forces of social change impacting the traditional family structure have also affected Chinese elderly in Hong Kong. In recent years, the primary social support system for the elderly has been impacted by small public housing units, which have not encouraged multigenerational households [124]. Consequently, many young adult children move to new towns outside Hong Kong, leaving elderly parents behind. Elders who have been socialized to expect to be comfortable and cared for in their old age instead find themselves isolated. Some in the younger generations have also redefined what filial piety is to them. For example, paying nursing care fees for an elderly family member may be considered a demonstration of filial piety in some families or communities [231]. Consequently, principles of filial piety are challenged.

The theme of respecting elders and filial piety surfaced in a qualitative study with Asian American immigrants. Participants in the study stated that adult children should support their elderly parents, especially if they have a successful life, and this value should be passed down [163]. Interestingly, Korean immigrants in Chang and Moon's study identified elder abuse in terms of "abrogation of filial piety" [43]. These acts included adult children not wanting to live with elderly parents, placing their elderly parents in a nursing home, or not showing adequate or proper respect. In Korea, the low birth rate and increase in one-child families have led to an expansion of the role of daughters. Traditionally, sons (and their wives) were expected to care for their elderly parents. In 1991, an equal inheritance ratio was legislated in Korea, and many have linked greater gender equity to the weakening of other cultural values, such as filial piety demonstrated by sons [272]. Many Korean adult children may have acculturated to new value systems that minimize familial responsibilities, particularly to parents.

Pang found a similar theme surfacing among Korean elderly immigrants [164]. Many resented living with their adult children and having to watch children, cook, and clean the house. They felt they had become full-time childcare providers. Because many elders did not regard discussing and negotiating these matters appropriate, the situation merely worsened. They classified these scenarios as abuse. Similarly, in a study with Vietnamese elders, Le found that some elders stated that their daughters-in-law did not want them to learn English or how to use the transportation systems [165]. Therefore, they were confined at home to do household chores as free laborers. They classified these behaviors as elder abuse. Interestingly, emotional abuse was pervasive, and it not only included threats of putting the elder in a nursing home, but the use of silent treatment and blatantly ignoring their presence.

In a study using focus groups with home care workers who worked with Chinese elderly, the theme of disrespect emerged prominently. Disrespect encompassed actions and attitudes that go against cultural norms of obedience, conformity, and filial piety. Such behaviors might include being bossy or rude, ordering an elderly person to leave the room for no reason, scolding, or being demeaning [166]. Disrespect led to social isolation among the elderly, and for some of these immigrant Chinese elderly, the social isolation was exacerbated by financial dependency or dependency on family members due to their low level of English proficiency. The dissonance experienced by the Chinese elders stemmed from their expectations of filial piety and being taken care of in their old age. When this did not happen, this led to loneliness and depression; in the elders' minds, this was a type of "abuse" [166]. Ultimately, what is considered disrespect is heavily influenced by culture; Asian culture-specific behaviors that may be considered disrespectful to elders include addressing them by name or not giving a seat of honor at the dinner table [269]. However, the boundaries are not clear as to when disrespect crosses over to abuse.

This concept of disrespect is not specific to Asian culture. A qualitative study of African American, Hispanic, and White custodial grandfathers found that the men discussed their grandchildren and children being disrespectful. Not listening and not appreciating them, which ultimately made them feel devalued and in their eyes, fell into the category of emotional abuse [167].

Cultural values and norms of family and family obligations also color elder abuse and how victims perceive the abuse. Sanchez noted that in the Latino/Hispanic culture, particularly for Mexican Americans in the study, *la familia* may play a role in the sanctioning of family violence [39]. A majority of the Mexican American elderly participants justified the violence, stating they had instigated it and that it was best dealt with within the family. The needs of *la familia* are considered paramount and are more valued than the needs of the individual [39]. Therefore, incidences of elder abuse would not be disclosed to authorities; rather, they would be kept within the confines of the family. Related to this is the theme of *verguenza*, which emerged during the study. The word means shame or losing face. Disclosing that one's child has mistreated a parent brings shame to the family and violates norms about *la familia* [39]. Yet, one study found that length of residence in the United States predicted caregiver neglect among elders in Latino families [38]. This raises the question of whether immigrants' emphases on family and family obligation decay with acculturation. The role of family in the maintenance of elder abuse warrants more empirical attention.

Tomita discusses similar themes in the examination of elder abuse within a Japanese cultural context [168]. The Japanese have a strong sense of "we-self" or "familial self," which is markedly different from the Western/American "I" centered self. Again, the elder abuse victim may feel it is necessary to relegate his/her individual needs so as not to jeopardize group harmony. Cultural norms of perseverance, silent suffering, and quiet endurance are valued, but these are also associated with victimization; consequently, victims do not necessarily perceive and label themselves as victims of abuse. For many Japanese, it is more important to protect the family and the community by not discussing with outsiders anything that is shameful and dishonorable [169].

For Native American Indians, the context of historical trauma considered in understanding elder abuse. Experiences with forced tribal relocations, forced removal of children, and the adverse outcomes of American colonization have created a backdrop of violation of human rights [230]. Some have speculated that these violations have eroded social infrastructures, contributing to abuse and violence [230].

Although there are few research studies focusing on ethnic minority families and elder abuse, there is a growing recognition that more scholarly empirical work is needed to increase the knowledge base in this area. Practitioners and scholars realize that understanding and highlighting the cultural context of

elder abuse will shed light on formulating culturally sensitive interventions for ethnic minority families and their elderly family members.

Role of Culture, Race, and Ethnicity in Help-Seeking Patterns

It has been said that ethnic minority elders experience multiple jeopardy. In other words, they are vulnerable to life stressors because of their age, being an ethnic and class minority, not being proficient in the English language, being unfamiliar with American institutions, and not having transportation or social support networks [170]. Furthermore, most ethnic minority elderly do not voluntarily seek out social, community, and mental health services. For example, in a study with elderly Korean immigrants from Los Angeles County, there was a disconnect with their views and their intention to seek help, even when they classified various scenarios as elder abuse [171]. For example, 91% of the elders stated the financial abuse scenario constituted elder abuse, but only 63.7% stated they would seek help. Consequently, it is important to step back and examine reasons for their reluctance because these factors are in part social and cultural, and lessons learned can be used to develop culturally sensitive interventions and programs for the ethnic minority elderly.

Language Barriers

Many ethnic minority elders may not be proficient in the English language. If the helping professional cannot communicate with the immigrant elder, the patient is less likely to disclose personal problems, particularly sensitive topics such as abuse [28; 172]. Not only is lack of English proficiency a barrier to help-seeking but it exacerbates social isolation, which can increase the risk for abuse [28]. However, many helping professionals in social services are not multilingual despite the efforts to recruit professionals who are both bilingual and bicultural. This becomes even more problematic in certain ethnic groups, such as the Chinese, who have numerous dialects.

Geographic and Operational Accessibility of Services

Often, social service and community agencies are located in areas that are not easily accessible to elderly individuals who may not be able to drive themselves. Thus, they find themselves relying on public transportation, which may not be reliable or convenient. In addition, many agencies operate traditional hours of service—weekdays, from 9 a.m. to 5 p.m. Again, because they must rely on their adult children who may be working, elderly individuals may find it difficult to gain assistance.

Financial Difficulties

Some elderly face increasing financial difficulties as they age. They are typically living on fixed incomes; some do not have Medicare, Social Security, or receive pensions [170]. Lack of health insurance and high costs of medical services can be a challenge for many immigrant elders, further exacerbated by not knowing how to navigate the health and social service systems [273]. Consequently, many elderly immigrants not only avoid seeking services but also put off seeking medical services and other necessities until the situation becomes extremely severe [123].

Stigma/Shame in Asking for Help

Fear and shame of disclosing abuse emerged as a dominant barrier to help-seeking among elder abuse victims in a 2022 systematic review [274]. As mentioned, the concept of shame in many ethnic minority cultures is very different from that of Western notions. In traditional Asian culture, for example, shame or loss of face extends to the collective unit, such as the family and community. Therefore, not only is the individual embarrassed, but the shame is also experienced by the entire family system, including one's ancestors [239; 240]. This similar theme appeared in Sanchez's study with Mexican American elders [39]. They revealed that incurring shame to the family is to be avoided at all cost, and only on rare occasions, when someone's life is in jeopardy, should outside agencies be involved. Often, preserving family honor takes priority [274]. In a study

comparing Koreans and Korean immigrants in the United States, both groups indicated that physical and financial elder abuse was the most severe form of abuse compared to other forms of maltreatment [154].

Attitudes and Definitions of Abuse

Some victims may view a behavior some identify as abusive as a normal part of life [239]. In a 2019 study, some participants perceived problematic behaviors as family conflict rather than abusive, and thus did not see a need for formal support [241]. A quantitative study found that Chinese elders who experienced psychological abuse had the lowest intentions of seeking formal or informal help [275]. In another study of African American elders, the participants tended to accept abuse as an implicit agreement or exchange for caregiving or for being allowed to remain at home (versus a nursing home) [242].

Importance of Keeping Individual Problems from Outsiders

Tomita's qualitative interviews with Japanese adult immigrants revealed the importance of not discussing problems with outsiders [169]. They emphasized that it was unacceptable to make any disclosures about any unpleasantness to outsiders, but instead they must always maintain and present a happy and untroubled countenance to the public. Incidences of abuse would bring dishonor to the community and should be hidden at all costs. Along with the belief that it is shameful to discuss family matters, some consider abuse to be a part of one's fate [243].

Mistrust of Mainstream Services

Many ethnic minority immigrant elders are simply mistrustful of Western mainstream services. In a study of 124 Korean immigrant elders, one of the themes that emerged was mistrust of third-party interventions as a deterrent in seeking help [173]. Elders who adhered to traditional values were less likely to seek formal help. Coupled with unfamiliarity with Western notions of mental health and health and institutional procedures, many prefer to rely on traditional healers. For example, some Mexican American elders seek *curanderos* (folk healers) for healing and spiritual guidance [172]. African Americans are often wary of government and legal entities, and African American elders tend to be more likely to seek help from spiritual leaders, family, and the community than from mainstream services [244]. Furthermore, many African Americans with strong ethnic affiliations are more likely to use prayer and forms of spirituality when they need help instead of seeking formal services [174].

Ambivalence Toward the Legal System

Another issue among many ethic/racial minority groups is ambivalence or fear of the established legal system. In one study, many of the participants (older African American, Hispanic, and White women) identified fear of police as a major barrier to seeking help through legal channels. Concerns that the police would not understand, demean the victim, and even trigger police brutality were expressed. There was also a perception that restraining orders or protective orders were ineffective and could exacerbate the abuse [175]. Since the 1980s, more tribes have developed legal codes for elder abuse [176]. However, these legal remedies mirror Euro-American legal standards, and they appear to go counter to tribal cultural values of collectivism, harmony, and healing. Legal punishment of the abuser may therefore be less effective, and some Native Americans may be reluctant to seek help through the legal system [176; 230].

This is not an exhaustive list of barriers experienced by ethnic minority elders. It does provide readers a glimpse into their social realities. Abuse and mistreatment take on a host of connotations, and then given the layers of barriers, many elders are reluctant to seek assistance from mental health professionals, physicians, and other authority figures.

ASSESSMENTS, INTERVENTIONS, AND MANDATORY REPORTING LAWS FOR ELDER ABUSE

This section will provide readers an overview of various assessments and interventions for practitioners when working with elder abuse patients, particularly with those from ethnic minority groups. An emphasis will be placed upon gleaning cultural values and belief systems and incorporating them into assessments and interventions so that delivery of services can be both culturally sensitive and relevant.

ASSESSING FOR ELDER ABUSE

Assessing for elder abuse does not merely involve asking the victim questions. It also involves asking oneself difficult self-evaluative questions such as: Do I hold ageist attitudes? How are these attitudes translated when I conduct an assessment? Do I believe that elders can be abused, even sexually abused? Because of pervasive ageist attitudes, practitioners often fail to acknowledge that some forms of elder abuse occur [177]. This may impact whether certain assessment questions are asked.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.

(https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed January 29, 2020.)

Strength of Recommendation: I (Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.)

Sengstock and Barrett recommend a two-step process in the identification of elder abuse [178]. The first step revolves around identifying elders who may be at risk for elder abuse, and the second step involves verifying instances of abuse. According to Sengstock and Barrett, certain situations may make some elders more vulnerable to elder abuse [178]. Any elder, for example, who is incapable of taking care of his/her own daily needs and is dependent on another person is automatically in an at-risk situation.

To screen elders who may be at risk, Sengstock and Barrett recommend that practitioners assess the following domains [178]:

- **Reason for visit to practitioner**: Presence of acute or chronic psychological or physical disability, elder's inability to participate independently in activities of daily living, reluctance of caregiver to give information about the elder's condition, delay in elder's seeking professional or medical assistance, and inappropriate caregiver's reaction to practitioner's concern may indicate an at-risk situation or potential abuse.
- **Family history**: Elders who grew up in violent homes, children who have antagonistic relationships with the elder, children's excessive dependence on the elder, use of substances such as alcohol or drugs by children, and children who were abused by the elder may indicate an at-risk situation or potential elder abuse.
- **Elder's personal/social circumstances**: Caregivers who have unrealistic expectations of the elder, elders who are socially isolated, and conflict in the family system may also warrant further questioning by the practitioner.
- **History of accidents**: Patterns of accidents that do not make sense should alert practitioners to potential abuse.
- **Healthcare utilization**: Health care "shopping," in which the victim does not have a regular physician because of the perpetrator's fear of detecting abuse. Infrequent visits to physicians and caregivers overanxious to have elders hospitalized may also be signs of an at-risk situation.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Academy of Family Physicians recommends that screening for cognitive impairment should be performed before screening for abuse in older persons.

(https://www.aafp.org/pubs/afp/issues/2014/0315/p453.html. Last accessed January 13, 2023.)

Level of Evidence: C (Consensus)

Jayawardena and Liao also encourage practitioners to inquire about the domestic relationship between the elder and caregiver and underlying issues and dynamics of control [179]. For example, the practitioner should ask about the duration and nature of the relationship and how much responsibility the caregiver is assuming. In trying to gauge control and power dynamics, the practitioner may want to ask about financial resources, power of attorney, and how decisions are made [179].

The presence of any of the above does not necessarily mean that the elder is a victim of elder abuse. Rather, the presence of these factors warrants further questioning and observations on the part of practitioners. Assessment is a dynamic and holistic process, taking into account both individualistic and environmental factors. Given the legal nature of abuse, it is also important for practitioners to determine whether they are conducting an assessment or an investigation; an investigation implies an adversarial component, while assessment is a collaborative process [180].

Another screening device is the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST). This is a 15-item tool that measures three aspects of abuse: violation of personal rights or direct abuse, characteristics of vulnerability, and potentially abusive situations. These 15 items were eventually reduced to six items, which were found to be as effective in identifying abuse as the original 15 items [60; 181].

Practitioners can easily incorporate these six questions into their assessment, and positive responses should raise a "red flag" [60; 181]:

- Has anyone close to you tried to hurt or harm you recently?
- Do you feel uncomfortable with anyone in your family?
- Does anyone tell you that you give him or her too much trouble?
- Has anyone forced you to do things that you did not want to do?
- Do you feel that nobody wants you around?
- Who makes decisions about your life, how you should live or where you should live?

The Elder Abuse Suspicion Index (EASI) is a five-item tool that provides practitioners with a very quick sense of whether there is potential presence of elder abuse [182]. It was originally developed for use by physicians and has been recommended by the U.S. Preventive Services Task Force, but it can be used by practitioners in diverse disciplines [245]. The following items comprise the index [182]:

- Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
- Has anyone prevented you from food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?
- Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- Has anyone tried to force you to sign papers or use your money against your will?
- Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

The Brief Abuse Screen for the Elderly (BASE) consists of only five questions and takes less than one minute to complete [183]. It is not meant to be administered to the client, but is designed to determine the practitioner's level of suspicion. It is ideally suited to be used in conjunction with a tool that assesses for actual elder abuse [183].

There is no shortage of elder abuse assessment tools, and seven new tools were published between 2015 and 2020 [276]. Although it is beyond the scope of this course to provide a comprehensive review of all elder abuse assessment tools, the National Center on Elder Abuse (NCEA) has compiled 46 assessment tools in their Tools Inventory. This inventory is available at https://ncea.acl.gov/Resources/Tools-Inventory.aspx.

The Centers for Medicare and Medicaid reporting includes the Elder Maltreatment Screen and Follow-Up Plan, which assesses the percentage of patients 65 years of age and older with a documented elder maltreatment screen and follow-up plan noted on the date of positive screen. This measure was created for the Physician Quality Reporting System and has been collecting data since 2009 [185]. Statistics from the first six months of 2012 indicated that there were more than 53.9 million reported cases of individuals who were eligible to receive a maltreatment screen when visiting their physician. Of these nearly 54 million reported cases, only 1,438 individuals were actually screened for maltreatment. The cases were reported by psychologists, geriatricians, and occupational therapists, among others [185].

Other guidelines for effective screening include [186]:

- Ask open-ended questions.
- Normalize the questions by stating to the patient that practitioners normally or routinely ask these types of questions.
- Ask specific and behaviorally oriented questions. For example, if you ask a patient if he or she has been abused, you will likely receive a negative response. Instead, ask specific questions, such as:
  - Has anyone ever hurt you?
  - Has anyone ever touched you when you did not want to be touched?
  - Has anyone ever taken anything that was yours without your permission?
  - Does anyone ever talk or yell at you in a way that makes you feel lousy or bad about yourself?
  - Has anyone ever threatened you?
- Explore any affirmatives to the above types of questions. Find out more about frequency, severity, what precipitates the violence, and the outcomes of the violence. Can the patient protect him/herself? What does the patient want to happen now?

Welfel, Danzinger, and Santoro encourage practitioners to interview family members separately [16]. The environment should be quiet and calm, as possible; it may take some time for the patient's story to emerge, and the practitioner should not rush this process [277]. This is more likely to elicit honest disclosures than interviewing elders and their family members together. An elder might feel embarrassed or intimidated and will refrain from disclosing abuse in the presence of family members. No family members should be discounted as possible perpetrators.

The American Academy of Family Physicians asserts that patients and caregivers should be interviewed separately when screening for elder abuse.

(https://www.aafp.org/pubs/afp/issues/2014/0315/p453.html. Last accessed January 13, 2023.)

Level of Evidence: C (Usual practice)

If the practitioner finds an elder is at risk, the next step is to investigate, report, and possibly verify the abuse [178]. One of the rapid elder abuse screening tools can be used, followed by a comprehensive assessment includes an examination of physical, psychological, and social characteristics of the elder and his/her family members and other significant others. It is important to note that physical abuse injuries are likely to be located in an upper extremity (e.g., arm, hand) or the maxillofacial, dental, and neck area [187]. After the assessment is completed, there should be a clear pathway of next action steps [277].

CULTURALLY SENSITIVE ASSESSMENT: CONSIDERATIONS AND GUIDELINES

Many ethnic minority groups such as Hispanics/Latinos, Native Americans, and Asian Americans emphasize the collective unit. Tomita, in her work with Japanese elder abuse victims, discusses their strong sense of "we-self" and "familial self" which causes some elders to relegate their individual needs for the good of the group [168]. Consequently, they are less likely to discuss or complain about elder mistreatment. If they do complain, they will make certain that there are no negative ramifications to the family member or the perpetrator [188]. Tomita recommends the following tasks be incorporated into assessment when working with ethnic minority elders who subscribe to cultural norms emphasizing group collectivity [188]:

- Explore the elder's level of collective self or commitment to the perpetrator. The practitioner, for example, can ask the elder if any of their finances, such as their pension, is shared with other family members and how they feel about this.
- Examine the cultural context of abuse.
- Assess the likelihood of employing outside interventions. Many ethnic minority families do not believe that family matters should be discussed with outsiders.
- Assess for subtle signs of psychological abuse and neglect. The practitioner can ask the elder about their relationships with family members and then listen closely to the elder's choice of words. Chang and Moon, in their study with Korean elders, found that when asked if the elder gets enough to eat, the elder may not directly say "no" [43]. Rather, they might say in a roundabout way that the daughter-in-law often says: "You don't really need that second helping of rice, do you?"

The practitioner's choice of words is also vital during the assessment process. The term "abuse" is often unfamiliar or may be considered taboo. In some ethnic minority groups, this term is difficult to translate. Therefore, it is more helpful to ask specific behaviorally oriented questions. For example, practitioners can inquire about a wide range of potentially abusive behaviors, such as intense child care duties, stealing money, silent treatment, and disrespect. Tomita also suggests that practitioners find culturally acceptable terms for assessment [188]. When working with Asian immigrants, the terms "sacrifice," "suffering," and other related terms may be more meaningful because the cultures maintain that life has much suffering and stress the need to persevere. It may also be beneficial for practitioners to ask if an older patient/client has heard or seen any instances of elder abuse [231]. This could engage the individual in a more in-depth conversation.

It is important for practitioners to remember that the elderly population is not a homogenous group [183]. Racial and ethnic diversity contribute to their heterogeneity, but there are other dimensions that practitioners may not consider, including sexual orientation.

INTERVENTIONS FOR ELDER ABUSE

Mandatory Reporting Laws

APS is situated in civil law, meaning that they are civil rather than criminal laws [218]. All 50 states have enacted legislation dealing with elder abuse, and they share many features with child abuse statutes. Elder abuse laws are also called APS laws because many states combine the protection of elders and disabled adults under one law [189]. They provide legal definitions of elder abuse, establish administrative channels for the investigation of and intervention in elder abuse, define who is mandated to report, and designate penalties for violations [16]. However, the specifics of state laws vary, and elder abuse laws may be ambiguous. Individual states are responsible for their own interpretations of the laws [190].

What follows is a brief review of the administrative channels for the investigation of elder abuse cases. It is important to remember that each state has different elder abuse statutes and they differ along three major areas: mandatory versus voluntary reporting; the targeted elder population to be served (e.g., some states focus on cognitively impaired or incapacitated elders); and the authority granted to elder abuse workers to investigate cases (e.g., some states require that the worker seek consent from the elder) [189].

In all 50 states and the District of Columbia, an APS agency has been designated to investigate reports of elder abuse [246]. This is the principal public agency that is responsible for both investigating reported cases of elder abuse and for providing victims and their families with treatment and protective services. Title XX of the Social Security Act makes it a federal requirement for states to implement APS in order to receive funds [191]. In most jurisdictions, the county departments of social services maintain an APS unit that serves the need of local communities [192]. In general, APS offers case management, emergency medical services, alternative housing arrangements, and help in obtaining Medicare, Medicaid, and aging services [191]. It is important to remember that, unlike the child abuse, older adults can refuse services or accept only partial services, even if APS substantiates an incident of abuse [246; 247]. In some cases, APS can petition the court for assistance after it has demonstrated probable cause [247].

As noted, elder abuse laws differ from state to state, and definitions, procedures, and training can likewise vary [248]. Tennessee, Virginia, and Texas uphold the principle of autonomy in that elders can refuse services. In other states, authorities can be called to intervene if elders refuse services [190]. Unlike child abuse statutes that mandate professionals in all states to report incidences of child abuse, there is less consistency among the states regarding mandatory reporting for elder abuse [16; 56; 192]. For example, practitioners may be mandated to report only in cases in which the elder is residing in institutional settings [16; 56]. The definition of elderly may also differ [56].

Those people who are designated as mandated reporters vary from state to state. In Illinois, for example, licensed counselors are specifically named as mandated reporters [192]. Twenty-one states and protectorates required mental health professionals to report; 17 required psychologists to report; 5 required family and marriage counselors to report; and 30 required social workers to report elder abuse [192]. All states except New York, the District of Columbia, and Puerto Rico require healthcare professionals to report, and failing to do so can result in penalties [249]. As with child abuse statutes, the practitioner does not have to prove that the abuse occurs before reporting; the practitioner must report even if he/she only suspects abuse. Only 75% of the state laws on elder abuse include a criminal penalty for failure to report [16]. To locate the number to call for specifics about your state's elder abuse laws or to report elder abuse, visit the NCEA's website at https://ncea.acl.gov/Resources/State.aspx [193]. The Elder Abuse Guide for Law Enforcement (EAGLE) site allows users to access specific state codes and mandatory reporting requirements. It is available at https://eagle.usc.edu/state-specific-laws.

Frequently, practitioners are reluctant to report elder abuse. It is estimated that less than 2% of suspected elder abuse cases are reported by physicians [194]. In one study with 358 primary care physicians, recognition of physical abuse was the lowest (70%); the highest rate was of sexual abuse (91%) [278]. Intention to report was low for physical abuse, emotional abuse, and neglect among physicians in the study. There are several barriers to reporting. First, many practitioners do not have a clear understanding of how APS operates. Many are not familiar with the elder abuse reporting laws, how they work, and/or who to contact if they were to report, and time constraints make it difficult to do additional research to locate the information given there are often competing responsibilities and priorities [279]. Second, practitioners fear they will make a bad situation worse or that nothing will change if they report the abuse [179; 194; 195]. Third, practitioners may also feel threatened for their own safety, and in some instances, it may be necessary to contact law enforcement as well [179; 195]. Some are also concerned that they are breaking the confidentiality of the elderly individual [194; 195]. If the potential perpetrator is a staff person, a sense of loyalty can impede the reporting of elder abuse [279]. Practitioners may be unsure due to lack of preparedness. There is a shortage of services for elders, particularly in rural areas, making it difficult to make proper referrals. In some rural areas, transportation barriers make it even more complex [196].

Ultimately, the effectiveness of mandatory reporting laws remains unclear. There does not appear to be a difference in the number of reports in states with and without mandatory reporting laws [226].

Education

Healthcare professionals can play a significant role in education and information dissemination. It is important to educate the victim by providing him/her with information about the nature of the problem, their options, and assuring the victim that he/she is not responsible for what has happened. Distribute literature about elder abuse when appropriate, and provide a list of emergency community resources (e.g., lock replacements, counseling, hotlines, shelters, meals-on-wheels, visiting nurse, adult day care). Family members also require education. The key is coordination of various professionals and organizations in order to provide education, technical assistance, and services [247]. Educating practitioners about elder abuse is also crucial. Interactive trainings, utilizing case studies, simulations, and role plays, are more effective [278].

Safety Planning

Practitioners should review safety planning with the elder. Components of safety planning involve encouraging the patient to have emergency numbers on hand; being able to identify warning signals that the violence might escalate; having bags packed in the event that the elder needs to leave immediately; and forming an escape plan by identifying all the exits. The elder should be encouraged to replace locks if necessary. Remember, older women and men do experience domestic violence or spousal abuse; and therefore, it is important to review safety planning. Again, safety planning should be done in such a way that it does not contradict the ethical principle of respect for persons; it should help keep elders safe but simultaneously empower them to change their situations [197].

Legal Assistance and Orders of Protection

Elders may require legal assistance to establish guardianships, revoke powers of attorney, and obtain orders of protection. Every state offers orders of protection for domestic violence. These orders are available for victims of provable violence perpetrated by a person to whom the victim is married or was formerly married, has a child in common, or is related by blood [198]. Some states extend the availability of orders of protection to include vulnerable adults [198]. Orders of protection essentially stipulate that the abuser must stay away from the victim and his/her home, vacate the home, and/or refrain from abuse or threats. In a quantitative study, researchers found that older men were less likely to

receive a protective order, and older women were less likely to have a second hearing [280]. Generally, requested protective orders tended to be for the petitioner's residence. Practitioners must be aware of the limitations of orders of protection and seek legal consultation for elder abuse victims. More states are expanding their definition of domestic violence to include other forms of family violence, including elder abuse [199].

Alternative Housing

Practitioners can discuss options for alternative living arrangements with elderly individuals. Depending on the situation, domestic violence shelters might be appropriate; in other cases, temporary stays in care facilities, senior housing, or shelters for victims of abuse may be preferred [200]. However, domestic shelters are not always suitable for elders, especially if they have limited mobility or require assistance with activities of daily living [218]. Always begin with the least restrictive arrangements. For example, does the elder have someone to stay with him/her? In addition, explore options such as home care arrangements and the issue of temporary or permanent alternative residences (e.g., a senior citizen residence, nursing home, shelters).

Providing services to elders at risk of abuse or who are victims of elder abuse is complicated. Practitioners must wrestle with issues of self-determination, mental competency, and, as discussed previously, inconsistency of elder abuse statutes from state to state. The concept of self-determination refers to the right of individuals to make their own decisions [201]. To truly self-determine, each person must have several alternatives that are feasible and appropriate to their situation. To complicate matters, in working with elder abuse victims, practitioners also must examine patients' levels of "learned helplessness," fear, and mental competency, all of which affect their ability to self-determine [201]. Consequently, working with elders requires a long-term casework approach—the building of a trusting relationship with the patient, referring, linking, and coordinating appropriate services, and providing counseling and support to the individual [201].

Prevention

Healthcare facilities often conduct background checks on their care providers. Families who hire care providers for their elder relatives should also conduct comprehensive background checks to reduce the risk of abuse. Family members may do some background checks themselves by calling references and verifying employment dates. With Internet technology, there are businesses that will conduct background reports for a nominal fee. Red flags that could indicate potential problems include [202]:

- Unsigned applications
- Gaps in employment that are not or are poorly reconciled
- Unanswered questions regarding criminal background
- References are friends or family members as opposed to previous employers/supervisors
- Names of past supervisors cannot be recalled
- Poor explanations for leaving other positions
- Excessive cross-outs and changes made on the employment application
- Background questions not answered

In some states, banks are mandated to report incidences of financial abuse of their elderly clients through APS [203]. However, many banks are concerned about legal liability despite the fact that there are immunity clauses for those who report in good faith.

In terms of general prevention, social services and other outreach programs can help with early detection and overcoming the barrier of isolation [231].

State of Elder Abuse Interventions

Although elder abuse has been the subject of intense research and debate for several decades, there remains little consensus about the effectiveness of any one particular intervention [250]. Studies that evaluate elder abuse interventions often have small sample sizes, lack methodologic rigor, and tend to rely on poor-quality evidence, making it challenging to definitively identify effective intervention and prevention services [250; 251; 252].

INTERPROFESSIONAL COLLABORATION AND PRACTICE

Interprofessional collaboration and practice (ICP) is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for patients and their families to improve health, mental health, and social and/or family outcomes [281]. ICP crosses professional boundaries, allowing providers to harness the skills and knowledge of their colleagues to achieve a common goal [282]. The lack of a universal definition of elder abuse results in professionals approaching the problem from different perspectives. Health professionals approach elder abuse from a health perspective, while legal professionals view elder abuse from an evidentiary and judicial perspective [283]. When practitioners collaborate with colleagues across disciplines, they can experience benefits such as increased job satisfaction, improved staff retention and working relationships, and higher levels of creativity when creating treatment plans [284; 285].

ICP teams for elder abuse include attorneys, law enforcement personnel, and geriatric specialists from the medical, nursing, and social work [286]. Forensic accountants might be necessary to identify and document financial abuse [292]. ICP teams might also include paraprofessionals, who can bridge the health, social, legal, and mental health care systems with members from different racial and ethnic minority communities. These paraprofessionals include religious leaders, cultural experts, translators, interpreters, and other frontline community workers [287].

One of the challenges to effective interprofessional collaboration is that professionals (and paraprofessionals) are typically socialized to their discipline's professional cultural norms and have not been exposed to other professional value systems. Further, when they enter the workforce, they continue to work in silos, making them unfamiliar with the professional goals, language, roles, and tasks of their colleagues from other disciplines. Furthermore, continuity of care can be a significant barrier due to the involvement of various systems and the marginalized and vulnerable populations involved [288]. Consequently, information sharing, communication, and mutual respect are essential. Staff buy-in and coalition building are necessary in promoting and sustaining ICP work [283; 286].

ETHICAL ISSUES

There are unique ethical issues for practitioners when dealing with cases of elder abuse. Practitioners should consider the following ethical issues.

Autonomy and Self-Determination

Autonomy is defined as an ability to control one's own life and is based on independence and freedom [204]. On the other hand, self-determination is characterized by the ability to make informed decisions and plans to fulfill personal goals [205]. Both autonomy and self-determination are important aspects of care and should be protected. In a systematic review, the ethical principle of autonomy emerged the most often in geriatric literature [289]. Autonomy issues involved human dignity and integrity, respect for the elders' wishes, the value of family members' views, and information given to the elders and family about diagnosis, treatment, and end-of-life interventions [289]. In some cases, the violation of clients' autonomy and self-determination is very subtle. For example, practitioners should consider whether the role of the practitioner's expert status inadvertently reinforces or mimics the power dynamic in an abusive relationship [206]. The abused elder should feel free to make decisions regarding his or her life or care.

The state may intercede when an individual cannot protect him/herself from harm. Referred to as *parens patriae*, the state's intervention allows agencies, such as APS, to provide voluntary and involuntary services for at-risk elders [207].

The balance between promoting self-determination and ensuring the welfare of the individual is a delicate issue. Practitioners should keep in mind that an elder's level of autonomy is not static. It will constantly change due to altering medical conditions and level of functioning. Therefore, is important to periodically evaluate the individual's level of autonomy to determine the balance between supporting self-determination and beneficence [197; 253].

It is important that practitioners be supportive of patients' decisions regarding care [205]. To this end, the National Association of APS Administrators and others have identified best practice guidelines to promote principles of autonomy and self-determination [207; 208; 253]:

- Seek informed consent from the elder.
- Discuss values and preferences with the elder.
- Avoid imposing one's own personal values on the elder, and support the client's values and preferences regardless of whether they conflict with one's own value system.
- Recognize the elder's individual cultural and personal differences.
- Involve the elder as much as possible with the intervention plan.
- Evaluate care plans that take into account physical safety, independence, and the client's values and preferences.
- Employ the least restrictive services first.
- Respect the elder's decisions.

Informed Consent

The issues of self-determination and an individual's mental capacity are components of assuring informed consent. Although protecting a client's self-determination is important, there will be times when a person cannot give informed consent or there are questions regarding the patient's degree of capacity [290]. If a client's capacity may be compromised, there are three courses of action that may be taken. A surrogate caregiver, ideally identified by the client via a durable health care power of attorney, could provide consent. Alternatively, the surrogate caregiver may give informed consent while the elder gives assent. Finally, the client may have created documents indicating consent for certain procedures or wishes (e.g., living wills, do not resuscitate orders) prior to incapacitation [209].

Confidentiality

The practitioner's duty to respect a patient's or client's privacy of information is referred to as confidentiality. Because a victim's trust has been violated, he/she may have difficulty trusting practitioners and may be reluctant to accept help [253]. If during any patient assessment abuse is suspected, the necessary steps of action will be dictated by the state laws regarding elder abuse [253]. Effective collaboration involving sharing information across various agencies to coordinate services to protect the elder is vital, as is the protection of the client's right to confidentiality. Ultimately, the promotion of confidentiality should not breed inaction [175].

Capacity

It is unethical to assume that all elders do or do not have the capacity to make decisions. If an elder abuse victim does not take action against the perpetrator or to end the abusive relationship, this does not indicate lack of capacity [198].

It is often assumed that with old age comes diminished intellectual ability, which is an ageist attitude [198]. Normal aspects of aging, such as hearing loss, may make communication difficult, which may in turn be misinterpreted as diminished capacity. Therefore, each patient's physical limitations should be taken into account and communication modified as necessary. This allows important information to be accurately conveyed and ensures that all decisions are appropriately informed [198]. It may be necessary to take more breaks or otherwise accommodate the elder's needs during appointments [218].

Beneficence/Maleficence

Beneficence refers to doing good and promoting the well-being of others, while maleficence is avoiding doing harm to others [291]. Because Western society views elders as vulnerable, practitioners may be inclined to engage in an intervention on behalf of the elder, believing it is in their best interest [290]. There is a continual ethical balance of promoting client autonomy and beneficence [290].

RESOURCES FOR PRACTITIONERS WORKING WITH THE ELDERLY AND ABUSE VICTIMS

The following resources are provided for practitioners to gain more information about various aspects of elder abuse as well as resources to get additional information about services to which to refer elders.

Administration for Community Living
https://acl.gov

Center of Excellence on Elder Abuse and Neglect
http://www.centeronelderabuse.org

Eldercare Locator
https://eldercare.acl.gov

Elder Justice Coalition
http://www.elderjusticecoalition.com

Futures Without Violence
https://www.futureswithoutviolence.org

National Long-Term Care Ombudsman Resource Center
https://ltcombudsman.org

National Academy of Elder Law Attorneys, Inc.
https://www.naela.org

National Adult Protective Services Association
https://www.napsa-now.org

National Center on Elder Abuse
https://ncea.acl.gov/

National Center for Victims of Crime
https://victimsofcrime.org

National Clearinghouse on Abuse in Later Life
https://www.ncall.us

National Coalition Against Domestic Violence
http://www.ncadv.org

National Institute of Justice
https://nij.ojp.gov

National Organization for Victim Assistance
https://www.trynova.org

National Online Resource Center on Violence Against Women
https://www.nsvrc.org/organizations/115

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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