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The prevalence of elderly abuse : a descriptive survey of case management records

Gwendolyn Brown
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**The prevalence of elderly abuse: A descriptive survey of case
management records**

Brown, Gwendolyn Joyce, M.S.

San Jose State University, 1989

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THE PREVALENCE OF ELDERLY ABUSE:
A DESCRIPTIVE SURVEY OF CASE MANAGEMENT RECORDS

A Thesis

Presented to

The Faculty of the Department of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By

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December, 1989

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and when to be silent.

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who gave me the strength and courage
to endure the process.

ABSTRACT

THE PREVALENCE OF ELDERLY ABUSE: A DESCRIPTIVE SURVEY OF CASE MANAGEMENT RECORDS

by Gwendolyn Brown

This study examined the nature of the abuse of elderly living in San Francisco County, focusing on characteristics of the abused and the abuser, types of abuse, reporting sources, and causal factors. Types of abuse examined were active and passive neglect, psychological abuse, material/financial abuse, physical abuse, and violation of rights. Roy's (1971) Adaptation Model and Steinmetz and Straus's (1974) role/stress theory provided the conceptual foundation for the study.

Fifty-seven case management files were selected at random according to victim's age, confirmation of abuse, and case status. Results were calculated and reported utilizing descriptive and inferential statistics.

The study revealed that physical violence was the most common form of elder abuse. The most common target was the white female, 75 years or older, living with a relative or one non-relative caregiver. Physical abuse by males was noted most frequently. Abusive incidents were most often reported by hospitals and clinics.

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Chapter 1

INTRODUCTION

Abuse, neglect, and exploitation of the elderly is a significantly widespread social problem within our society today (Pierce & Trotta, 1986; Quinn & Tomita, 1986). It is a difficult problem to resolve because it usually occurs in the home behind closed doors. Due to our societal norms, professionals and the public at large often have a hard time believing that anyone would abuse an elderly person. The primary targets of this sort of abuse are the elderly who are ill and dependent on others for their care and well-being. Many psychologists have suggested that the home and the family are the important link for providing the comfort, care, and security needed by most seniors who are trying to live life to its fullest during their golden years (Pillemer & Wolf, 1986). Is this a fact, fallacy, or mere wishful thinking? Would it, then, be fair to assume that the home is the place where one can find love, understanding, and support even when all else fails? In fact, identification with the family should give each member a satisfying, self-defining relationship, enhancing stability with the development of a positive self-concept, and provide each individual, inclusive of elders, with a strong sense of personal worth (Pavalko, 1971). As a

matter of fact, it would certainly be safe to conclude that close family relationships are the ideal and most desirable through life, especially with the aging adult, unless the insular family becomes a source of torment and abuse rather than one that provides sustenance and support. So it is inconceivable to the majority of people that the greatest number of elder abusers are family members.

Although at the present time there is no reliable documentation on the prevalence of elderly abuse, researchers believe that from 4% to 10% of older persons, or from 1 million to 2½ million, are being abused and neglected (Pillemer & Finkelhor, 1988). Furthermore, as our aging population continues to increase from 3% of the population in 1900 to 11% in 1990, our family structure, extended care facilities, and long-term care systems are identifying a syndrome of elder abuse and neglect (Fulmer & Cahill, 1984). This trend is supported by the 500,000 to 2,500,000 cases of elder abuse reported by the Senate and House of Representatives Special Committee on Aging (1980). This is an unfortunate consequence for older Americans.

Mandatory reporting laws now hold all health care professionals responsible for reporting any suspected cases of elder abuse, neglect, or mistreatment. However, there are no uniform laws for the protection of the abused elder, and each state has its own legislation for regulating the

mandatory reporting of this act against seniors (Thobaben & Anderson, 1985). Establishing definitive federal mandates governing the handling of elder abuse cases, formulating uniform guidelines that would address this problem, and providing a comprehensive theoretical framework to be used by the geriatric practitioner or social service agencies in response to abuse occurring within the aged community might be the answer.

Future forecasts predict that the number of neglected and abused elders will increase. The overwhelming challenge for health care professionals responsible for the care of the aged will be in adequately responding to and meeting the ever-changing needs of the elderly, who will be living longer, with the likelihood of increased physiopsychosocial dependence because of fewer visible or available social and material resources.

Problem Statement

It has been well documented in the literature that abuse in the elderly community frequently occurs at the hands of family members and other direct caregivers (Kosberg, 1988; Wolf, 1987). What causes the family's role to break down, causing it to fail to provide the expected nurturance? Some common evaluations point to the caregiver being over-burdened from having to take full responsibility in providing for the elderly person, who may be mentally or

physically impaired. The caregiver may also be tired, alone, frustrated, hopeless, and under enormous stress. Physical impairments and social losses of the elderly compound the problem, and the older person may then be classified as a high-risk individual specifically targeted and vulnerable for abuse and neglect within the domestic setting. After further investigation of this problem area, researchers have identified the following groups of elderly persons who are at high risk for family-mediated abuse or neglect: (a) those living at home whose care needs exceed or soon will exceed the family's ability to meet them; (b) those whose primary caretakers are demonstrating signs of stress; (c) those in family settings with an identifiable norm of any form of family violence in the past or present; (d) those who abuse drugs or alcohol or who have a history of loss of control; and (f) those whose primary caretaker is under severe external stress caused by the loss of a job, illness, or family problems (Eastman, 1984; Falcioni, 1982; Galbraith & Zdorkowski, 1984; O'Malley, Everitt, O'Malley, & Campion, 1983; Sengstock, Barret, & Graham, 1984).

Consider for one moment the abuse or neglect of a small child. It deeply stirs society to sympathy, anger, and action. And rightly so! The phenomenon of child abuse is a health and social problem requiring the marshaling of

society's forces for intervention, treatment, and prevention in order to increase the quality of life for the child. Yet the abuse or neglect of the elderly person is not as likely to bring that same indignation. It is frequently rather subtle, a matter of simply not meeting the needs of the elderly person as a result of the caregiver's maladaptive response to stressful internal or external problems (Falcioni, 1982; Hickey & Douglass, 1981) or, even more distressing, so greatly minimizing those needs as to be able to deny their very existence (Bahr, 1987). So it would appear that society is uninformed about the problem of elder abuse or neglect, often does not recognize it as such in its virgin state, and, therefore, passively helps to perpetuate it.

Among the greatest concerns are identification of abuse cases, protection of individual rights of self-determination and privacy, due process for both the abused and the abuser, and provision of adequate services and delivery systems to meet all of the needs. There is no denying that the problem of elder abuse does exist. More is coming to light as research studies reveal the facts about elderly abuse, thus alerting professionals to the elders' needs in cases of abuse. In spite of these studies, professionals working with the elderly are generally not sufficiently educated to detect and record

abuse; thus, incidents often go unreported (Lau & Kosberg, 1979). How will consistent detection and intervention be accomplished within the community of elders so that its spread and continuance will be kept in check? Public awareness and education of both the layperson and the health care professional is the most direct and immediate way of preventing the physical, emotional, and material injury to the older members within the culture.

Research Questions

This study was undertaken to answer the following questions:

1. What is the scope and nature of mistreatment of the elderly living outside institutional care facilities within San Francisco County in western California?
2. Are there identifiable profiles for abused elders or their abusers in San Francisco County similar to the profiles found by other state or national researchers?
3. Which individuals are most likely to report elder abuse within the geriatric community at large?

Purpose and Need

The purpose of this descriptive research study was to determine the prevalence and nature of mistreatment of the elderly within the confines of the senior community of a large metropolitan city. This study provided insight into the types of abuse and identifiable profiles of abused

seniors and their abusers, as compared to previous research surveys. It is of particular interest to note that seniors are not their own best advocates for reporting abuse and initiating the identification phase of the detection process. The professionals in the community remain the primary source for notifying the appropriate authorities regarding the victimization of the elderly.

The literature purports that the older the person, the higher the risk for abusive behavior (Kosberg, 1988; O'Malley et al., 1983), and older persons, especially older women, who are dependent upon others for their care are more vulnerable to abuse than those who are not dependent (Freeman, 1979; Powell & Berg, 1987). Are these claims valid, and can this limited study offer any positive support for these theoretical propositions? If these suppositions are correct, gerontologists will have clear direction for planning future intervention strategies to prevent this ever-growing social problem from growing larger.

Operational Definitions

The definitions utilized by this study categorize the various forms of abuse and neglect:

1. Elderly abuse, or dependent-adult abuse, refers to physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment resulting

in pain or physical or mental suffering, or deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering (Elder Abuse Task Force of Santa Clara County, 1987).

2. Psychological abuse refers to situations in which "the elderly person is insulted, treated as a child, frightened, humiliated, or threatened" (Gray Panthers of Austin, 1983, p. 2).

3. Material/financial abuse refers to the illegal or improper act of using resources belonging to an elderly person for monetary or personal benefit (Lau & Kosberg, 1979).

4. Physical abuse refers to instances where the "elderly person has been hit, slapped, bruised, sexually molested, cut, burned, or physically restrained" (Gray Panthers of Austin, 1983, p. 2).

5. Violation of rights refers to preventing or attempting to prevent an aged person from exercising normal control over his or her own life, for example, forcing the person to move, not permitting a move, or prohibiting a marriage (Sengstock & Barrett, 1986).

6. Active neglect refers to situations in which "the abuser withholds items necessary for daily living, such as food, medicine, money, or bathroom assistance" (Gray Panthers of Austin, 1983, p. 2).

7. Passive neglect refers to instances that generally involve harm resulting from inadequate knowledge of caring for the elderly. It is characterized by situations in which "the elderly person is left alone, isolated, or forgotten" (Gray Panthers of Austin, 1983, p. 3).

8. Stress refers to a function of the interaction of the subjectively defined demands of a situation and the capabilities of an individual or group to respond to those demands. Stress exists when the subjectively experienced demands are inconsistent with response capabilities (Straus, Gelles, & Steinmetz, 1980).

9. Developmentally impaired refers to any type of mental or physical impairment.

Research Design

A descriptive study utilizing a retrospective case analysis approach was undertaken to determine the prevalence of elderly abuse within the aged population of a large metropolitan city, as reported by one of the county's social service agencies. The case management records of 57 clients already known and identified by social and civil authorities as abused elders were examined. Each met the following criteria: (a) client was 60 years of age or older, living in the community, (b) the elderly victim suffered one or more forms of elder abuse, and (c) the case

was either closed or had reached the state of legal intervention at the time of data collection and file review.

For the purpose of this investigation, the elderly population was defined as all persons 60 years of age and older and living outside institutions prior to civil intervention in the 12-month period from January, 1988, through January, 1989. An introductory letter was sent to the social agency's general manager (Appendix A), with follow-up consent being procured from the agency's senior supervisor (Appendix B). Review and approval by the Institution Review Board, Human Subjects, at San Jose State University preceded all data collection, with full endorsement for continuance of this planned research endeavor and its unequivocal conviction that this investigation would not pose any significant harm to the involved persons or institutions.

The project study and procedures were explained to all involved and/or affected persons, reiterating the fact that all information would be considered privileged and confidential, and no names would ever be used. The records of 57 cases of abused and neglected elderly persons were selected from the absolute total number of reported and confirmed cases from the previous 12-month span. The systematic, non-random sample was chosen from the total

number of abused elders on record from the preceding year by selecting every third case until a sample of 57 cases was obtained. The research data were transposed from each case management file to the Abuse Report Form (Appendix C) by the agency supervisor or appointee.

The survey tool was a modified version of an instrument used by Block and Sinnott (1979) in a research study investigating the battered-elder syndrome in another large urban community of senior residents. The Abuse Report Form (ARF) allows for recording information and characteristics about the abused and the abuser, types of abuse, and reporting sources, as well as the intervention strategy that was used in each case. The abused elders' anonymity was protected through careful and direct handling of the files by the supervisor or an appointee. Thus, the confidentiality of clients was observed from the time of the initial selection process until the final case management file was determined, with names being kept totally concealed from the researcher. In order to formulate answers for the research questions, descriptive statistics for each item on the ARF were generated.

Results are reported in the form of percentages, frequencies, and/or averages, depending upon the level of measurement of the variable. The overall benefits are that the results may provide for corroboration or contrasting of

data already obtained from other research projects exploring some of the questions common to this thesis study. The final statistical data obtained will be shared with the involved agency, with the possibility of providing additional information for staff use.

Scope and Limitations

The research design allowed the sample to be randomly selected, an essential element in eliminating bias and skewing in the reporting and, consequently, conclusions being generated from the research data. The representatives of the sample size might pose some concern; therefore, generalizations made to include the geriatric population as a whole may not apply in all circumstances. This limitation is acknowledged, but with statistical application this variable could be sufficiently controlled (Best, 1981; Polit & Hungler, 1983). Due to the sensitive nature of the solicited information, it is also possible that inhibition of the abused person contributed to the highly emotional content of this subject matter, yielding erroneous or less-than-factual data. Contrasting or comparing the data from this study with national research data and figures would help to validate or give support to any inferences made in this study.

Since agency personnel serve in the capacity of "gatekeepers" in all of the abuse research efforts, it is

imperative that studies of this kind attempt to obtain data from the widest possible range of agency types. This is particularly true in view of the fact that several studies have noted that the types of abuse seen by professionals vary considerably from one type of agency to another (Hickey & Douglass, 1981; Sengstock & Liang, 1982).

Inasmuch as this study focused on only one agency, it is conceivable that the results could prove very different from data collected from legal, law enforcement, or public health agencies. Thus, if available, comparative data from other studies done within similar agencies may yield mutual and corroborative data regarding the nature and incidence of elder abuse in the community.

Specifically excluded from this study was abuse by personnel in residential institutions, such as skilled nursing facilities. This problem may indeed be widespread and serious, and it could have a significant impact on the prevalence factor, but it was not the focus of this study.

The most challenging aspect in this area of research has to be in teaching the subject of investigation of elder abuse to health care professionals so that they will be expert field observers. If this information about aged abuse can be ascertained from primary as opposed to secondary sources, then case detection, intervention, and effective treatment will be expedited. The shared

information derived from the first-hand experiences of case finders will help in reducing the prevalence rate.

A futuristic outlook concerning techniques for collection of data in the study of domestic violence, especially abuse of the elderly, would include interviews using conflict resolution and random response techniques, conjoint and collaborative interviews, and perhaps focused observation (Gelles & Straus, 1978). At present, locating subjects and data sources seems to be the major problem in the investigative study of abuse within the elderly community.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

Conceptual Framework

The concepts attributed by Steinmetz and Straus for stress/role theory (1974) and Roy's Adaptation Model (1971) constituted the conceptual framework for this study. Steinmetz and Straus's theory was utilized because it offered predictive explanations for elderly abuse and/or neglect, and explained how internal or external stressors affect the behavior of the abuser, leading to the violence perpetrated onto the elder. Roy's Adaptation Model (1971) proved to be the most promising in providing a more complete conceptual base and frame of reference for health professionals working with families who may be identified as violent and abusive. Roy's theory uses a holistic approach to the elderly abuse syndrome in the context of the domestic setting in examining the victim, the perpetrator, the environment, and the helping professionals as important components in the process of detection and prevention of mistreatment of the senior living in the community.

Unfortunately for many community elders, many families have been found guilty of inflicting physical and emotional wounds that persist or are even inflicted in old age. In

fact, recent studies suggest that abuse in early childhood provides the basis for a particular lifestyle in old age, and presently there is an alarming amount of ruthlessness directed against the elderly by those closest to them who were abused by them as children (Gunby, 1979; Pearson, 1982). Steinmetz (1978) reported that much mistreatment of seniors turns out to be in the form of neglect as opposed to actual severe physical battering. The literature supports the fact that of all the types of elder abuse addressed in this study (see Operational Definitions, page 7), only cases of neglect have been widely documented (Anderson, 1981; Beck & Phillips, 1983; Dubin, Garcia, LeLong, & Mowesian, 1987). But for the injured, the experience of mistreatment is real and something to deal with on a daily basis in spite of the optimistic evidence of its having limited occurrence within the community.

Overt episodes of assault and battery against elders have been documented, as well as covert acts of omission where elders have been left to deteriorate without adequate clothing, food, shelter, or health care intervention. Five types of abuse constitute the battered elder syndrome:

- (a) physical abuse, (b) material/financial abuse,
- (c) psychological/ verbal abuse, (d) self-neglect, and
- (e) violation of rights (Gray Panthers of Austin, 1983; Lau & Kosberg, 1979; Powell & Berg, 1987).

Symptomatology of Abuse

There are a number of signs and symptoms, as described by Block and Sinnott (1979), that are often present with elder abuse and should signal the case finder to investigate further. In the case of physical abuse, the health worker should be alerted by clinical symptoms that are inconsistent with the patient's clinical history. This becomes particularly difficult when the elderly individual has cognitive deficits and exhibits confusion and disorientation. In such cases it may be necessary to locate the primary care provider and assess the nature of the injury and its causes. In other cases of suspected abuse, especially when mental ability is intact, careful questioning may indicate fear and resignation on the elders' part regarding the nature and quality of their care. In the case of physical neglect, it may be even more difficult. If the primary care provider is knowingly withholding the treatment and resources necessary to maintain the well-being of the elder, it is clearly a case of elder abuse. However, in cases that appear to indicate neglect, it is important to assess the primary caregivers' level of understanding about the resources available to them, and the elders' willingness to accept care.

In the case of psychological abuse, assessment of evidence of abuse has many judgmental aspects. What may

appear to be an angry, abusive exchange may be an example of a life-long pattern of communication between the care provider and the elder. Suspicions of the health care professional should be validated by psychiatric consultation to make a determination regarding the case in question. Such consultation provides invaluable support to the health professional faced with such a situation, especially when the elder denies such abuse to protect the alleged abuser.

In the case of material abuse, the theft or misuses of money or property, if suspected, should be carefully approached. The professional must be very clear about what belongings are involved. When an elder reports theft of property or money it may be necessary to report the complaint to the police as well as state agencies that require elder abuse reports. When an elder is coerced to give belongings away in return for adequate care, the elder is clearly the victim of material abuse and in need of support to resolve the situation and regain the property. Caution must be exercised at this point, especially if the perpetrator involved is a relative or long-standing care provider. Legal counsel is warranted.

Medical abuse can be detected by the professional who monitors an elderly person's responses to various medications, therapies, and required prostheses. If an

elderly individual is not receiving such prescribed life-sustaining and life-enhancing therapies, the professional will need to explore the circumstances surrounding such action and report cases of medical mistreatment.

Violation of rights is the prevention or attempt to prevent an elderly person from exercising normal control over his or her own life. An example of this kind of abuse would be when the elder has been forced to move, is not permitted to move, is denied a desired marriage arrangement, or otherwise coerced, imprisoned, or abandoned. A forced removal of an elder from his or her home, especially involving commitment to a nursing home, should bring suspicion of possible abuse in the form of violating the rights of the elder, unless the elderly individual is in fact gravely disabled and in need of such placement.

In the case of all types of suspected elderly abuse, application of reliable assessment instruments such as Ferguson and Beck's "H.A.L.F.--A Tool to Assess Elder Abuse Within the Family" (1983) or Tomita's "A Protocol for Health Care Professionals" (1982), along with expert observation skills of trained professionals, can prove invaluable in the investigating and reporting process of elder abuse.

Related Theories

Role Theory

There are a number of theorists, such as Green (1980) and Steinmetz (1977), who believe that abuse is a learned behavior and typical of "the violent family." According to these researchers, persons abused as children are likely to be abusive parents, and they sooner or later become the perpetrators responsible for the abuse of the elderly parent. This theoretical proposition may be an explanation for elder neglect or abuse inasmuch as the research literature clearly documents the parallels between "granny bashing" and child abuse (Johnson, 1979). The similarities are quite striking, clearly suggesting a learned family behavior. Notably, there are several profound characteristics commonly shared by the elder and the child. First, both children and dependent seniors rely on others for their basic needs. Secondly, both can be heavy emotional, physical, and financial burdens. Thirdly, the young or old victims of abuse are tucked out of sight in the supposed sanctuary of the family home. These factors alone can help set the stage for abuse and retaliation from the primary caregivers (Anderson, 1979), and help formulate one prominent theoretical framework to provide explanation and comprehension of this domestic violence.

When Harbin and Madden (1979) observed families with battered parents, they found the most common pattern was one of repetitive or threatened attacks on the parents, most of whom were 40 to 70 years old. In many cases the behavior seemed to have become a habitual family transaction occurring at those times when the family was under stress. The attacks often began with threatening behavior, such as destroying furniture in front of the parents while verbally assailing them, and climaxed with a serious physical attack on one or both parents that, in some case, resulted in hospitalization. The violent behavior was often rewarded and, naturally, perpetuated when the parent submitted to the child's demands.

Any social psychologist would predict that if a particular method of resolving conflict was perceived to be successful, that method would likely be repeated for resolving the next problem. Abuse is no exception to this pattern of learning. The empirical data on homicide, assault, child abuse, violent crimes, and violence between family members definitely tend to indicate that violent individuals grew up in violent families and were also frequent victims or perpetrators of familial violence (Gelles, 1972).

In viewing supposedly normal contemporary families, particularly those making up the middle class of our

society, Stark and McEvoy (1970) found that between one fourth and one fifth of the adults they surveyed felt it was acceptable for spouses to hit each other under certain circumstances. In other studies, some couples conceded that they had, on at least one occasion, used physical force (Straus, 1973) and physical aggression (Freeman, 1979) to resolve marital conflict in the past year. Violence and physical force have even been translated into "right" and "normal" ways of disciplining children by certain cultural dictates (Steinmetz, 1977; Steinmetz & Straus, 1974).

Society, for the most part, seems to condone, if not perpetuate, violence through support of the violent activities in the media and sports arenas. Steinmetz (1977) and Heiss (1976) found that families often resort to physical violent abuse as a problem-solving method, so that the family members learn from early in life to use this method to solve problems throughout their lives. Simply interpreted, abusers behave in the ways they learn within the family context, and, unfortunately, they are given few real opportunities in this society to relearn alternative methods for resolving conflicts. Interestingly enough, violence begets violence (Fulmer & Cahill, 1984), and these aggressive tendencies are apparently retained into adulthood, throughout successive generations, as child

& Lefkowitz, 1971). Thus, the health professional can be instrumental in providing significant resources within the community for the abuser to learn alternative, less violent ways to deal with stress and conflict within the domestic setting.

Stress Theory

Another prominent theory that deserves attention in offering predictive explanations for elderly neglect and/or abuse is one derived from Steinmetz and Straus (1974), which emphasizes the effect of external stresses on the abuser, the stressed caretaker. Stress on the abuser is seen as being one of the precursors in elderly abuse. The theoretical framework proposed by these researchers emphasizes that stress, internal or external, can trigger abusive behavior requiring a target, the abused elder. Thus, actions that add to existing family tension precipitate further battering and complete a characteristic profile of the abuser. Illustration of this theoretical posture can be reviewed in Johnson's (1979) models of child abuse and elderly abuse (see Figures 1 and 2), from which two common precipitating factors can be readily identified. Stress and family conflict, along with set social roles, are the recognized precepts that emerge and intensify the nature of familial dynamics. At present it appears that there is a definite relationship between child abuse and

Child Abuse Operational Definition

Figure 1. Child abuse operational definition.

Note. From "Abuse and Neglect: Not for Children Only" by D. G. Johnson, 1979, Journal of Gerontological Nursing, 5, p. 12.

Abuse of Elderly - Proposed Operational Definition

Figure 2. Abuse of elderly proposed operational definition.

Note. From "Abuse and Neglect: Not for Children Only" by D. G. Johnson, 1979, Journal of Gerontological Nursing, 5, p. 12.

elder abuse models in terms of reciprocity in family patterns of modes of interaction. If this hypothesis is valid, the cycle of violence and abuse in some family circles may very well extend itself from the cradle to the grave (Freeman, 1979).

Further support documenting this cyclic effect of violence that leads to abuse comes from the works of Blenkner (1965), Farrar (1955), and Goldfarb (1965). These researchers contend that there are definite patterns of violence that continue from generation to generation. Moreover, early life deprivation or abuse and dependency issues may arise again as insurmountable conflicts unless resolved with the maturation of the individual. Such would be the case when the care of the elderly parent or a juvenile dependent became an overwhelming burden, thus increasing the risk of abuse. Podnicks (1983) maintains that abuse often takes place when caregivers are overworked, underpaid, and unduly stressed.

A study by Kosberg (1988) showed that dealing with problems of an aged parent is very stressful for the adult children, especially if the elder is physically or mentally impaired. The problems created had numerous sources-- financial, physical, psychological, social, dealing with family relationships and housing. The incorporation into the nuclear family of an additional person who is seen as

dependent, roleless, or non-contributing, and whose problems create additional stress within the family, can in many cases lead to neglect and abuse of the elderly, as it does to abuse of the child. Most investigators agree that high stress levels are usually associated with intrafamily abuse (Rathbone-McCuan & Voyles, 1982; Steinmetz & Straus, 1974) or mental impairment (Beck & Phillips, 1983; Lau & Kosberg, 1979), because the stress imposed on the caregiver is substantially compounded.

The battering of elderly parents is a serious problem just beginning to receive public attention. Steinmetz (1978) maintains that if the 1960s was the decade of interest in child abuse, and the 1970s was the decade of spouse battering studies, the 1980s will probably be known as the decade of interest in the abused elderly parent. In theory, as persons live longer with smaller incomes, many couples will have no alternative but to support their elderly parents within their homes. Forecasts concerning this situation will probably reveal that a lack of emotional and physical preparation for that care will lead to increasing family stress and, in many cases, abuse of the elderly parent.

So far, theories presented have dealt with the individual dimensions or the dynamics encompassing the elder abuse syndrome to provide a basic understanding of

and explanation for this domestic violence. Elder abuse has been seen by many researchers to be the mirror image of child abuse, with a recurring manifestation of ineffective role modeling in response to stress. The inadequacy of the abuser leads to acts of violence and mistreatment of dependent elderly family members. Since violence and abuse in the domestic setting have clearly been shown to be cyclical, the geriatric phase is the next chronological step to completion of any isochronal familial tendencies. Thus, with the causal perspective comes the suggestion from learned behavior/role theory and stress theory that the abuser often responds to stress or unsurmountable conflicts in an inappropriate manner, which is often modeled from the behavior that was learned in the domestic setting. Ideally, the health professional would have already identified this family, and the juvenile would have been taught more constructive ways of handling stressful conflicts. If not, then the once-abused becomes the abuser. Therefore, it is hoped that the helping professionals will intervene on behalf of the abused elder and bring help to the entire family unit.

Both of the aforementioned theories provide excellent explanations for elderly abuse by highlighting the stressed caretaker. These theories are limited, however, because they exclude the victim and the practice discipline, which

are important in the attempt to reform the maladaptive family. Roy's (1971) Adaptation Model, on the other hand, provides a theoretical framework with a holistic approach focusing on the interconnection between the elder (abused), the family (abuser), the environment (stressors), and the helping professionals for the detection and prevention of elderly abuse.

Adaptation Theory

Among the existing theoretical frameworks, Roy's Adaptation Model seems most suitable for application in describing the health professional's role when working with the abused and the abuser within the domestic environment (Roy, 1976; Roy & Roberts, 1981). The model is basically described as a "systems theory" (Chin, 1980), with "interactionist" levels (Roy & Roberts, 1981), where the individual is viewed as an adaptive system. When the adaptation process of the person or family unit results in changes that promote integrity of the individual by means of growth or self-mastery, it is, in effect, deemed to be an adaptive response. On the other hand, the response is defined as maladaptive when the stress of the presenting stimuli is greater than the level of the residual assets, failing to adequately support and maintain the individual's biopsychosocial integrity (Roy, 1971). The basic accepted assumption is that the person's adaptation is a function of

previous exposure to stimuli and the subsequent adaptation level (Roy, 1976). To maintain a healthy state of being, the system has two major mechanisms--the regulator and the cognator--used for adapting to, or coping with, environmental stimuli such as stress (which is viewed by Galbraith & Zdorkowski [1984] as a common denominator in elderly abuse). This dual mechanism keeps the whole system in balance, with a feedback-type process based on the individual's perception. In the case of elder abuse, it is very likely that perceptual defects occur as a result of the overwhelming environmental stresses and increasing dependency needs of the elder (Springer & Brubaker, 1985). During the battering episodes the caregiver exhibits ineffective adaptation responses leading to further abuse and other maladaptive behaviors. The health professional subscribing to Roy's Adaptation Model will focus care for the battered elder on assisting the client's adaptation in physiological needs, self-concept, role function, and interdependence relations along the health-illness continuum process (Roy & Roberts, 1981). The entire family's needs will likewise be addressed positively, involving intervention for support and provision of the needed resources.

Application of the Model

Whenever abuse is suspected, Roy's Adaptation Model blends effectively with the nursing process or problem-solving mechanism (Fawcett, 1984). Fawcett described the process, which encompasses six major steps.

Assessment phase, level 1. This phase includes data collection regarding the person's internal and external behaviors for each of the adaptive modes (physiological needs, self-concept, role function, and interdependence). The health care professional then categorizes the behavior as adaptive or ineffective.

Assessment phase, level 2. This includes identification of ineffective adaptive responses judged as requiring immediate attention due to threat to life or integrity of the individual, family, or community. A family in which elder abuse exists would be an example of a family in a need-deficit state determined by the assessment process, occurring as a product of the ineffective adaptive modes exemplified by the abused and the abuser. An assessment tool that could be utilized during this phase is Ferguson and Beck's "H.A.L.F.--A Tool to Assess Elder Abuse Within the Family" (1983). This data collection tool assists in documenting the objective and subjective responses of the client, validating the possible existence of elder abuse within the family, and identifying family

members' need deficits and asset characteristics. H.A.L.F. measures the Hhealth status of the family, its Attitudes toward aging, its Living arrangements, and its Finances, and is a reliable predictor of elder abuse.

Problem identification involves the professional diagnosis of the client's adaptive and ineffective behavior responses. This diagnostic phase includes a statement of the most relevant factors contributing to the elder and/or family behavior. Phillips and Rempusheski's (1985) Decision Model may be advantageous in diagnosing and intervening in elder abuse and neglect. The health professional's diagnosis would determine the actions to be taken, including the following: (a) needs no intervention, (b) needs further assessment, or (c) needs immediate intervention. The nursing literature lists stress of the caregiver and the total dependence of the elder as major sources of the problem of elder abuse (Springer & Brubaker, 1985). In fact, O'Malley, Segars, Perez, Mitchell, and Knuepfel (1979) found that abuse usually happened repeatedly to the same person and that in 63% of the cases, stress associated with caring for the elderly was a precipitating factor. At the conclusion of this stage, a completed professional assessment and diagnosis would have listed all of the high-risk factors that were identifiable within the domestic environment.

Goal setting. Problem identification allows goal setting through mutual agreement of the health professional, client, and/or family member. Since abuse, as experienced by the elder within a familial setting, is a symptom of the family's dysfunction caused most often by stress and dependency, goals are formulated in terms of the expected client behavior in response to professional intervention. The overall goals for a family identified as being over-stressed by care for a dependent aged parent would be stress management training for the caregiver, with supportive care for the elder in health maintenance and functioning.

Professional intervention involves professional manipulation of the focal, contextual, and residual stimuli, with the client actively participating in the entire process. For the abused elder and his or her caregiver, the nurse would, out of necessity, manipulate the role function and interdependence modes of adaptation by helping to decrease caregiver stress (using education and community support) and modifying the dependent role of the elder (using community resources) to attain goals. This phase could include a multidisciplinary team approach.

From a strictly professional standpoint, whenever elder abuse or neglect is suspected, the first consideration should always be the safety of the older

individual. If there is any doubt, protective service actions should be employed. If this means temporarily providing alternate shelter or guardianship for the elder, it is a responsible mode of action whenever danger is a real possibility. Such measures can be reversed if the suspected allegation proves to be unfounded, so such intervention is the preferable response to ignoring the situation or waiting until injury or a fatality occurs, as long as the professional acts in good faith.

Evaluation is the final step in implementing Roy's Adaptation Model. The process is judged effective if the desired goals are met and the system exhibits adaptive behavior after professional intervention. Ferguson and Beck (1983) listed three goals and intervention strategies to be attained in elder abuse: (a) decrease of abuse risk factors by way of education, (b) early diagnosis of abuse dynamics to secure prompt treatment by way of role changes, and (c) reduction of the effects of abuse by way of respite or intradomestic care for the aged person.

Summary

The gerontological nurse/health professional can utilize Roy's Adaptation Model in conjunction with the nursing process to maintain a high level of well-being, utilizing effective adaptive responses to promote survival, growth, reproduction, and self-mastery. Assessment of the

client's behavioral responses to environmental stimuli establishes a nursing diagnosis. Health goals are attained with the professional manipulating the client's environment while carrying out intervention strategies. With elder abuse this would have to include both the abused and the abuser. The overall goal would be to help create a safe environment for the elder by eliminating high-risk factors inherent in the senior, the caregiver, or the domestic environment. Evaluation concludes the process by establishing coping mechanisms for the system's continued ability to adapt to the numerous environmental stimuli. Since adaptation in role functioning within the domestic setting is an important feature for healthy family interaction, Roy's Adaptation Model and Steinmetz and Straus's stress/role theory are conceptual frameworks that could be beneficial in working with dysfunctional families trying to work through this often devastating human experience.

Review of the Literature

Prior to 1983 the literature contained only five direct studies that included 10 or more cases of abuse and neglect of non-institutionalized elderly persons (O'Malley et al., 1983). These studies differed widely in their definitions and in their methods (see Table 1). All included categories such as passive and active abuse

(Douglass, Hickey, & Noele, 1980); misuse of drugs (Block & Sinnott, 1979; Lau & Kosberg, 1979); and violation of rights (Lau & Kosberg, 1979), such as forced placement into nursing homes or forced confinement. Three studies relied on information gained from recollection of health care providers by mail surveys or personal interviews (Block & Sinnott, 1979; Douglass et al., 1980; O'Malley et al., 1979). Two studies were based on retrospective chart reviews (Lau & Kosberg, 1979; Steurer & Austin, 1980).

Although definitions and methods differed widely, the researchers generally agreed with the observations reported in most cases. The victims tended to be predominantly old and female. Persons over the age of 75 have disproportionately more reported abuse than others, and women outnumbered men in all groups. Seventy-five percent had significant physical or mental impairments and were unable to meet their daily care needs without assistance. In over 60% of the case reports, the elderly person was a significant source of stress to the abuser. In 75% of reported cases the profile of the abuser pointed to many areas causing significant stresses such as alcoholism, chronic medical problems, or financial difficulties. The abuser was a relative in 86% of the reports, living with the elderly person in 75% of cases. The episodes of abuse frequently recur in nearly 80% of the reported cases.

Table 1

Published Reports of 10 or More Cases of Abuse

Authors	<u>N</u>	Definitions	Methods of Case Gathering
Block & Sinnott (1979)	26	Physical abuse, psychological abuse, material abuse, medical abuse	Mail surveys from professional, mail surveys from elders, case reports
Douglass et al. (1980)	89	Physical abuse, verbal or emotional abuse, active neglect, passive neglect	Interview with professionals
Steurer & Austin (1980)	12	Physical abuse, verbal/psychological abuse	Record review
Lau & Kosberg (1979)	39	Physical abuse, psychological abuse, material abuse, violation of rights	Record review
O'Malley et al. (1979)	183	Intentional infliction of physical pain, injury, or disabling mental anguish, unreasonable confinement, or deprivation by a caretaker of services that are necessary to maintain mental and physical health	Mail surveys of professionals

Note. Adapted from Elder Abuse: State of the Art (p. 4) by M. O'Rourke, 1980, Boston: Legal Research and Services for the Elderly.

Physically apparent trauma was cited in over 50% of the reports. Table 2 presents types and frequency of abuse.

Another finding of interest was that the types of abuse and neglect observed differed with the professional population surveyed by Hickey and Douglass (1981), who found that all professionals interviewed had more experience with neglect and emotional abuse than with overt physical abuse. Police and mental health workers reported physical abuse more often than did the other professionals. Physicians rarely reported cases despite extensive contact with the elderly (Hickey & Douglass, 1981; O'Malley et al., 1979).

The most extreme form of parental assault/abuse was parricide (i.e., the murder of a person who stands in a relationship held to resemble that of a father [e.g., ruler of a country], mother, or other close relative [Hellstein & Kalila, 1965]). As would be expected, the families in studies of parricide were severely disorganized and often catastrophically stressed. Often there was only one extremely violent and legal action by the child or adolescent. Parricide is often associated with severe parental sexual and physical abuse of the child, and the parental victim is frequently a sadistic figure hated by the whole family (Tanay, 1973).

Table 2

Types and Frequency of Elder Abuse

Type of Abuse	Reported Episodes ^a		Percentage of All Victims with Type of Abuse ^b
	<u>n</u>	<u>%</u>	
Observed trauma	161	52%	
Contusions	81	26%	44%
Malnutrition	30	10%	16%
Lacerations/abrasions	22	7%	12%
Fractures	14	5%	8%
Sprains/dislocations	8	3%	4%
Freezing	4	1%	2%
Burns	1	0%	1%
Oversedation	1	0%	1%
Other Reported Abuse	148	48%	
Mental anguish	74	24%	40%
Verbal harassment	20	7%	11%
Financial mismanagement	8	3%	4%
Unreasonable confinement	7	2%	4%
Sexual abuse	6	2%	3%
Other or unclear	33	10%	18%

Note. Adapted from Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals (p. 7) by O'Malley et al., 1979, Boston: Legal Research and Services for the Elderly.

^an = 309. ^bn = 183.

At the present time, approximately 32 studies of elderly mistreatment have been completed (Hudson, 1989). Highlighting just a few recent research studies reveals investigation of neglect and abuse (Phillips & Rempusheski, 1985), ethical aspects (Gilbert, 1986; Quinn, 1985), causative agents (Anetzberger, 1987), public knowledge (Tornstam, 1989), and prevalence (Pillemer & Finkelhor, 1988). Language and terminology about elder abuse still have not been standardized to establish a common frame of reference for researchers and professionals in the field. An example of the inconsistencies in terminology and definitions utilized by the professionals in research investigations examining elderly abuse can be seen in Table 3. Until common definitions can be developed, sound research and theoretical development that will be cohesive and unified in terms of contributing to the understanding of this devastating social and health problem cannot be derived. To date, study findings remain insufficient to document an absolute value on the incidence, prevalence, antecedents, causes, contributing factors, or consequences of elder mistreatment (Hudson, 1989).

In spite of the above-mentioned citations from the literature on elderly abuse, there have been a few studies that contest these findings. Pearson (1982) reiterated the point that millions of older persons do lead contented,

Table 3

Researchers' Definitions of Elder Abuse Terminology

Authors	Definitions
O'Malley, Segars, & Perez (1979)	Abuse: The willful infliction of physical pain, injury, or debilitating mental anguish; unreasonable confinement; or deprivation by a caretaker of services which are necessary to maintain mental and physical health.
Block & Sinnott (1979)	Physical Abuse: Malnutrition; injuries, e.g., bruises, welts, sprains, dislocations, abrasions, or lacerations. Psychological Abuse: Verbal assault, threat, fear, isolation. Material Abuse: Theft, misuse of money or property. Medical Abuse: Withholding of medication or aids required.
Douglass, Hickey, & Noele (1980)	Passive Neglect: Being ignored, left alone, isolated, forgotten. Active Neglect: Withholding of companionship, medicine, food, exercise, assistance to bathroom. Verbal or Emotional Abuse: Name-calling, treating as a child, frightening, humiliation, intimidation, threats. Physical Abuse: Being hit, slapped, bruised, sexually molested, cut, burned, physically restrained.
Lau & Kosberg (1979)	Physical Abuse: Direct beatings; withholding personal care, food, medical care; lack of supervision. Psychological Abuse: Verbal assaults, threats, provoking fear, isolation. Material Abuse: Monetary or material theft or misuse. Violation of Rights: Being forced out of one's dwelling or forced into another setting.

(table continues)

Authors	Definitions
<hr/>	
Wolf & Pillemer (1984)	<p>Physical abuse: the infliction of physical pain or injury, physical coercion (confinement against one's will), e.g., slapped, bruised, sexually molested, cut, burned, physically restrained.</p> <p>Psychological abuse: the infliction of mental anguish, e.g., called names, treated as child, frightened, humiliated, intimidated, threatened, isolated.</p> <p>Material abuse: the illegal or improper exploitation and/or use of funds or other resources.</p> <p>Active neglect: refusal or failure to fulfill a caretaking obligation, including a conscious and intentional attempt to inflict physical or emotional stress on the elder, e.g., deliberate abandonment or deliberate denial of food or health-related services.</p> <p>Passive neglect: refusal or failure to fulfill a caretaking obligation, excluding a conscious and intentional attempt to inflict physical or emotional distress on the elder, e.g., abandonment, nonprovision of food or health-related services because of inadequate knowledge, laziness, infirmity, or disrupting the value of prescribed services.</p>
O'Malley, Everitt, O'Malley, & Campion (1983)	<p>Neglect: Failure of a caretaker to intervene to resolve a significant need despite awareness of available resources.</p> <p>Abuse: Active intervention by a caretaker such that unmet needs are created or sustained with resultant physical, psychological, or financial injury</p>

Note. From Inadequate Care of the Elderly: A Health Care Perspective on Abuse and Neglect (pp. 18-19) by T. T. Fulmer & T. A. O'Malley, 1987, New York: Springer.

productive lives with their children or other family members; they do live in harmony, peace, love, and freedom from abuse. However, evidence also abounds to indicate that the so-called normal families are not conflict-free and that they use considerable amounts of both verbal and physical aggression in resolving conflicts. The obvious difference is that families not labeled abusive apparently use less violent coping mechanisms to resolve conflicts than do families labeled abusive.

Summary

The family, that supposedly most sacred of institutions, has been found guilty of sometimes inflicting the physical and emotional scars that persist or even begin in old age. In fact, conclusions drawn in recent studies suggest that abuse in early childhood provides the basis for a particular lifestyle in old age, and presently there is an alarming amount of ruthlessness directed against the elderly by those closest to them (Gunby, 1979). In her study of elder abuse, Steinmetz (1978) reported that much of the mistreatment of seniors turns out to be in the form of neglect as opposed to physical battering. The literature supports the fact that of all the types of elder abuse addressed in this study (see Operational Definitions, page 7), only cases of neglect have been widely documented

(Anderson, 1981; Beck & Phillips, 1983; Dubin, Garcia, LeLong, & Mowseian, 1987).

It appears that stress plays a major role in the incidence of elder abuse. The stress may result from past family conflicts that involve struggles in the family or from the stress that caring for a dependent person can bring. Since physical and mental impairments of the elder were found to be actively related to the abusive episodes, health practitioners must work to help eliminate the stressors within the environment. Like child abuse and spouse abuse, there also seems to be several intervening variables that may increase the likelihood that the abuser will react to the stressful situation in a violent and abusive manner, due to the strong influence of intra-familial role modeling compounded by inadequate adaptive skills (Quinn & Tomita, 1986). These may include a family history of extreme violence, unemployment of the abuser and/or family breadwinner, a personal loss, an alcoholism or drug addiction problem, or an emotional or mental health problem that makes it difficult for the caretaker to cope. The obvious connection between stress and elderly abuse suggests the need for expanding medical and social agencies' ability to respond to the needs of the abused elder, once identified by the community professional. Roy's (1971) Adaptation Model, along with Steinmetz and

Straus's (1974) role/stress theory, can provide a viable frame of reference for the helping professionals working with unhealthy families, so that both the abused and the abuser can find support and harmony. Adapting to and successfully coping with all the internal and external stressors is the key to preventing violence and the unfortunate abuse of the elderly.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

This study utilized a descriptive design to acquire and confirm information regarding the mistreatment of the elderly within the community, as reported by the Adult Protective Service (APS) agency. This design was chosen because it allowed replication, re-analysis, and comparison of data already gathered by investigators whose aim also was to gain greater insight into this prevalent yet often hidden social problem. The primary difference can be seen in the methodology of data gathering and analysis, as well as a focus on the aspects of case identification essential in the prevention of elderly mistreatment. Secondary analysis and reproduction have been shown to be important research methods, providing validity for conclusions derived by other investigators making inquiries regarding a common subject matter (Best, 1981).

Sample and Setting

The research sample was drawn from the total number of cases reported to the APS from January to December, 1988, of the previous 12-month span. Every third case management file was selected to create the final sample for this research study. The sample consisted of 57 abused elderly who were 60 years of age or older and not living in an

institutional care facility. Of the 57 subjects, 40 were females and 17 were males, with ages ranging from 61 to 99 years.

The setting for data collection was the APS, located in a large metropolitan city in western California. This agency is the official local establishment designed and mandated by state laws for investigating all reported allegations involving adult abuse within the county and community at large (Rathbone-McCuan, 1980).

Methodology

This section addresses the data survey instrument and data collection procedures used in this simple descriptive research design. This study utilized a retrospective approach for collecting data from actual cases of elder abuse victims and their abusers.

Data Survey Instrument

This study used a research survey tool called the Abuse Report Survey (Appendix C), designed by the researcher to provide information in five major areas: (a) demographic data on victim, (b) type of abuse sustained, (c) reporting source, (d) demographic data on perpetrator, and (e) intervention action taken. The data were collected from the subjects' case management files and recorded on the abuse report survey form. A complete description of each of these areas of research follows.

Demographic Data on Victim

The demographic data section of the tool provides for collecting information on age, sex, ethnicity, responsible caretaker, and degree of physical or mental impairment of the abused elders. Because the data collection approach was retrospective, information was not always available for recording. The report of physical or mental impairment of the elder served as a positive indicator for identifying families with high-risk factors, or stressors, that could lead to abuse and/or neglect.

Type of Abuse

The definition of elder abuse greatly affects its estimated national incidence and markedly hampers the progress in consolidating knowledge from investigation, study, or instruction necessary for theory development (Salend, Kane, Satz, & Pynoos, 1984). It would not be an overstatement to say that the difficulty in establishing a uniform definition has become a primary impediment in the development of an adequate knowledge base on elder abuse. For all practical purposes in this research study, elder abuse means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment resulting in pain or physical or mental suffering or deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental

suffering (Elder Abuse Task Force of Santa Clara County, 1987). Each type of abuse was separated into the following categories: (a) physical/medical abuse, (b) psychological abuse, (c) material abuse, (d) violation of rights, and (e) self-abuse. Many of the reported cases involve multiple types of abuse occurring in diverse patterns.

Reporting Source

The APS agency, a sub-unit of the department of social services or public welfare agencies in each state, is the designated governmental organization intervening on behalf of an aged person who may be at risk for physical or emotional harm. As such, mandatory reporting of physical abuse and all other forms of abuse occurring within the community must be filed with the APS. Once reported, the APS case management person assesses and identifies the potential or actual abuse victim. If high-risk factors exist, the agency is mandated to effect positive and, perhaps, permanent change for the abused elder in terms of living arrangements or responsible caregiver.

Professionals working with the elderly are generally not alerted to detect and record abuse; thus, incidents often go unreported (Lau & Kosberg, 1979). Consistent detection and intervention are necessary to halt the spread or continuance of elder abuse within the community. Are nurses in the community serving as the primary

professionals reporting abuse? Which group of professionals appears most skilled in the assessment and prevention of abuse within the ranks of our senior citizens? This research indicator is significant in helping to determine actual professional groups to be targeted for education and training in the investigative process.

Information on Perpetrators

Although there is very little information available on elder abusers, demographic data were collected on the abusers' age, sex, ethnicity, and relationship to the victim. A comparison was made relating the sex and relationship of the abuser to the abused. Steinmetz and Straus (1974) provided the causal and theoretical perspectives to explain the inappropriate behavior of the abuser within the context of the domestic setting.

Action Taken

Once elder abuse is diagnosed, intervention focuses on protective services, referrals, counseling, and/or education. Research identifying the most frequently used community resource agencies gives direction in determining service needs of that particular social establishment, be it private or public.

Data Collection

Data were collected employing a retrospective case analysis approach, which extended over a 12-month period beginning in January, 1988, and extending through December of the same year. Each eligible case for the study met the following criteria: (a) the elderly victim was 60 years of age or older, (b) it had been established by the APS caseworker that some form(s) of elder abuse had occurred, and (c) the case was, at the time of review, in a state of closure.

Approval for this study was granted by the Institutional Review Board for the Protection of Human Subjects at San Jose State University. Because of the sensitive nature of the research content, letters were also written with information of the study and requesting the consent of the division head of Social Services (Appendix A) and the director of the APS (Appendix B), where the research sample was obtained. The study was approved for clearance with the assurance that anonymity of subjects would be maintained throughout. The APS was offered the opportunity of receiving a copy of the study results.

Confidentiality

The first and foremost consideration, even before data could be collected, was that of concealing the identity of the victims from the researcher so that their permanent

anonymity could be maintained. This was accomplished by careful handling and extraction of the needed data from each case management file that had been selected from January to December, consequently generating the sample population for the study. A number was assigned to each case management file to ensure the confidentiality of the victims and to ease future reference for the researcher. With the assistance of the Agency Director, the researcher transferred the needed data to the research instrument.

Selection

It was noted with interest that the case management records were filed in sequential order by month and date reported. This ultimately proved to be ideal for selecting the sample population for this study. A modified random selection process was used in which every third case was chosen. Likewise, it was recognized at the onset of the study that due to the agency's function in the community and empowered scope of jurisdiction, selecting an initial heterogeneous and exclusive sample of elders meeting the specific criteria for the study would require a two-stage process. As has been previously emphasized, the APS is responsible for the joint county and community coordination, intervention, and referral of all cases involving adult abuse. Therefore, it was determined that the initial selection process would most likely not

generate a pure sample of seniors aged 60 and over. During the study period, a total of 224 abuse cases were reported to the APS regional unit of western California. As was anticipated, 18 of the originally 75 selected sample cases were disqualified because the victims were under 60 years of age.

The second and final phase of the enumeration process produced the desired sample of abused elders for the research study. A simple elimination of ineligible reported cases from the original 75 selected formulated the final sample ($N = 57$) to be studied.

Data Analysis

With the study criteria met and the final case management files determined, statistical analysis of the data extracted from the APS records was the next step. Analysis required a comprehensive review of all the data collected based on the research questions posed by the study from recorded information on the statistical data forms. Variables were coded, categorizing important demographic characteristics of the abused and the abuser, the various circumstances under which abuse occurred, type(s) of abuse documented, reporting source, and case management intervention technique utilized. To assist in the interpretation of information, quantitative data were obtained in the form of frequency distributions giving

counts and percentages of the various categories of information.

It is important to note certain limitations of the data collection process in that the case records suffer, in varying degrees, from missing information for some variables. Furthermore, while the case records for the mistreated elders were completed on the standard abuse forms, with only a few exceptions, the data represent the memory and judgment of personnel from a wide range of professional occupations. As a result, information describing type of abuse may be categorized and reported differently.

Since the study utilized a small regional sample, the size is an acknowledged limitation. Accordingly, the results may not be totally applicable to include all like agencies or the general population of seniors. Intentional exclusion of abused elders residing in residential institutions such as nursing homes would have a positive impact on the reported prevalence rate. Even though the investigator recognizes that this problem may be widespread and serious, it was not the focus of this research. Other possible skewing of the results may be due to the sample's having been drawn from an extremely large urban community of seniors.

In spite of the aforementioned limitations, the significance of the findings of this research study provide practical information that the health professional may utilize in the event of suspected mistreatment of elders. This study also clearly documents the community at large. Although the statistical population is on a small regional scale, it has importance in revealing the prevalence rates for the various types of mistreatment, and allows for the identification of individuals most responsible for case-finding efforts within this community of seniors. A more universal finding would be validation of results obtained by previous researchers regarding demographic information on the abused and the perpetrators. Although recent research is revealing more and more about elderly abuse, there are still many areas that need investigating so that information can help halt the occurrence of this familiar problem.

Chapter 4

DATA ANALYSIS AND INTERPRETATION

The results and analysis of this study are presented in a descriptive statistical form. Analysis required a comprehensive review of all the data collected from the Adult Protective Service (APS) agency case management files. The conclusions derived were directly consistent with the age group from which the sample was drawn. Likewise, the data are presented in tabular configurations to provide ready reference.

Characteristics of Victims

Fifty-seven cases of elder abuse of various types were reported by the APS in San Francisco County from case management records of 1988. Table 4 provides a brief description of the characteristics of the 57 abuse victims. Victims ranged in age from 61 to 99 years; the majority of victims ($n = 22$, 39%) were in their 70s. Forty (70%) were female, an expected finding because the aged population is predominantly female. There were 17 abused males in the study, constituting 30% of the sample. Forty-three (75%) were white, six (11%) were black, six (11%) were Asian, and two (4%) were of unknown ethnicity. Interestingly, the rates of abuse and neglect were higher for white elderly victims than for minority victims. This study appears to

Table 4

Characteristics, by Frequency and Percentage, of Aged Abuse
Victims Seen by the APS (N = 57)

Characteristic	Number of Cases	Percentage
Age ^a		
60-69	13	23%
70-79	22	39%
80-89	20	35%
90-99	2	4%
Sex		
Male	17	30%
Female	40	70%
Ethnicity		
Asian	6	11%
Black	6	11%
White	43	75%
Unknown	2	4%
Responsible Caretaker		
Son ^b	8	14%
Daughter ^b	5	9%
Spouse ^b	7	12%
Other Relative ^b	5	9%
Non-Relative ^b	15	26%
Resides Outside	17	30%
Type of Impairment		
Developmentally Disabled	41	72%
Mentally Disabled	2	3%
Physically Handicapped	7	12%
Brain Impaired	5	9%
Functionally Impaired	1	2%
Unknown	1	2%

Note. Total does not equal 100% due to rounding.

^aRange = 61-99 years. ^bResides with the abused.

support earlier findings (Block & Sinnott, 1979; O'Malley et al., 1979) that victims of elder abuse are more likely to be female and over the age of 75. Those 75 years of age and older represent only 37% of the total elderly population, but this study found 83% of the victims to be 75 or older, considerably more than the population suggests. In addition, women appear to represent a proportionately larger share of the abused population than their numbers in the general population suggests.

It has been suggested that physically or mentally impaired elderly are likely to suffer abuse (Block & Sinnott, 1979). This did prove to be the case with the abuse victims reported by this APS agency. Findings indicate that a majority of the elderly victims had at least one impairment that was so disabling that the elder required the assistance of others to meet daily living needs. Fifty-six of the victims had reported impairments of a physical or psychological nature. Of the 57 cases examined in this study, 21 abusers (37%) were relatives of the victims residing in the victim's home. Non-relative caretakers living with the mistreated elder who were identified as abusers comprised 26% ($n = 15$). This factor alone is highly suggestive of probable elder dependence and a greater likelihood that the victim was a real source of stress to the abuser, with a high risk of being abused.

Types of Abuse

This study found all types of abuse, and some cases involved multiple forms. When multiple abuse was present, the combination of physical and emotional abuse was found most frequently. Table 5 presents each type of abuse reported to the APS as examined by this study. Physical abuse was encountered with 49 of the victims. Within this category of abuse is actual assault and battery. One victim sustained injuries that eventually led to the victim's death. Physical constraint, deprivation, and neglect were cited in 8 of the reported cases. This included deprivation of assistance needed for basic daily living. Sexual abuse was identified in one case where the male victim was abused by the responsible primary caretaker, his roommate.

The second most often reported type of abuse was psychological abuse, which included any form of chronic verbal aggression and mistreatment such as insults, swearing, or verbally threatening behavior by the perpetrator. Fifteen of the victims suffered this type of abuse. Although psychological abuse as a single category was reported in only 27% of the cases, the possibility of multiple dynamics should be remembered when considering the

Table 5

Characteristics and Reporting Sources of Abuse, by
Frequency and Percentage, Suffered by APS Clients (N = 57)

Characteristic	Number of Cases	Percentage
Type of Abuse^a		
Physical/Medical		
Constraint/Deprivation	4	7%
Neglect	4	7%
Sexual	1	2%
Assault/Battery	40	70%
Self-Abuse		
Neglect	5	9%
Suicide	1	2%
Psychological		
Verbal Assault	14	25%
Mental Suffering	1	2%
Material ^b		
Theft	1	2%
Misuse	5	9%
Both	1	2%
Violation of Rights	0	0%
Reporting Source^b		
Private Agency	22	37%
Public Agency	4	7%
Hospital/Clinic	24	40%
Public Health Agency	3	5%
Police	5	8%
Other ^c	2	3%

Note. Categories are not mutually exclusive.

^aMultiple abuse possible. ^bMultiple reporting possible.

^cLong-term care facility.

statistical data represented in this study. The occurrence of psychological and physical abuse may often be overlapping and co-existing in many of these abuse cases.

Material abuse was seen in seven cases, which constitutes only 12% of the cases represented in this study. Material or financial abuse, the perpetrator's illegal or improper use of the elder's resources for monetary or personal benefit, was the least frequent type of reported abuse.

Violation of rights was not encountered in this study. One reason for this may relate to the low socioeconomic conditions that often typify residents of large urban cities. In other words, the financial loss resulting from removal of an elder from the home to a skilled nursing facility (SNF) would be seen as more devastating to the significant others than the efforts to deal with the stress and burden of providing care for the dependent geriatric.

The findings of this study are in marked contrast to one by Powell and Berg (1987), which suggested that the most common type of elder abuse is financial abuse. If clear ideas about the nature of elder abuse are to be obtained, it is critical that information be gathered from similar and dissimilar agency types and sources.

Characteristics of Abusers

Table 6 presents a summary of characteristics of abusers. In over half of the reported cases, the abusing person was a relative and over the age of 50 years. The youngest perpetrator was a 31-year-old male, and the oldest was a 90-year-old friend. In 21% of the cases reported, the abuser was the son of the victim; daughters were abusers in only 7% of the cases. Relatives were implicated in 77% of the reported incidents; spousal abuse was reported in 12 (21%) of the cases. Six cases involved self-abuse, which appeared primarily in the form of neglect and which, without a doubt, presents another frontier for gerontological exploration. Five of the victims were mistreated by caretakers who were not relatives, and in two of the cases the abuser was not identified by the victim. In 28% of the cases it was intimated that the perpetrators were other relatives (e.g., grandsons and in-laws). Abuse by sons and spouses followed closely, with each of these categories representing 21%. Daughters and non-kindred relatives were implicated in 7% and 9%, respectively, of the cases reported.

Males were identified as perpetrators in 58% of the cases, and females accounted for 25%. This finding is consistent with the data composite for the male gender in this study. The perpetration of elderly abuse was

Table 6

Characteristics of the Abuser by Frequency and Percentage(N = 57)

Characteristic	Number of Cases	Percentage
Relationship to Abused		
Non-Kindred ^a	5	9%
Spouse	12	21%
Daughter	4	7%
Son	12	21%
Other Kindred	16	28%
Unknown	2	4%
Excluded ^b	6	11%
Ethnicity		
Asian	6	11%
Black	5	9%
White	28	49%
Unknown	12	21%
Excluded ^b	6	11%
Sex		
Male	33	58%
Female	14	25%
Multiple Abusers	6	11%
Unknown	4	7%
Age		
Under 40	3	5%
40-49	4	7%
50-59	4	7%
60-69	2	4%
70-79	1	2%
80-89	2	4%
90 or older	1	2%
Unknown	40	70%

Note. Totals do not equal 100% due to rounding.

^aPractitioner/custodian. ^bSelf-abuse.

witnessed 49% for Whites, 11% for Asians, and 9% for Blacks.

Reporting Source

In 93% of the cases, abuse was reported by someone other than the victim. In these instances the APS was made aware of the abusive situation by a community social agency by means of the report of the victims to agency personnel or upon routine physical examination. In five of the cases the APS learned of the abuse from the law enforcement agency; in one case, from the SNF; and in another, from a home health agency referral board (i.e., extended care facility). In 42% of the cases, hospitals and clinics reported elderly abuse to the APS (Table 5).

Action Taken

Since the law mandates that immediate intervention strategies or referrals to appropriate agencies be made on behalf of the abused elder once abuse has been confirmed, the APS case management worker initiated protective actions directly in 34 (60%) of the cases. In 14 (25%) cases, the APS agency representative worked with the reporting social agency, indirectly overseeing the management strategies instituted and validating their effectiveness. Five of the study cases required no action from the APS or reporting agencies, and four victims refused services.

Despite the fact that the APS agency has been set up to intervene on behalf of elderly persons at risk of abuse, none of the seniors being mistreated in this study reported this occurrence directly to the agency. One obvious explanation could be fear by the elder of retaliation by the abuser. Further study is needed in this area in order to formulate any firm conclusions or inferences about the elderly's failure to report their mistreatment directly to the APS agency. Thus, generalizations cannot be made to include the vast population of seniors in the community due to the limited sample size.

Chapter 5

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Although elder mistreatment is probably not a new phenomenon, there is a relatively new awareness in our society that some seniors are mistreated. Investigation of abuse, neglect, and mistreatment of elders by their families is a monumental task for researchers of this social ill because often both victims and abusers wish to maintain secrecy. Usually the level of competence of the victim is brought into question, focusing on the elder's reliability to report the alleged mistreatment. Then abuse becomes extremely hard to prove. For example, every abused victim in this study apparently experienced great difficulty in reporting their mistreatment to the legal authority. As a consequence, the incident had to be formally catalogued by the representative of the Adult Protection Service (APS) agency. Without any concrete evidence it can only be hypothesized that elders do not report the abuse to the authorities due to fear, social isolation, financial dependence, lack of knowledge, or mental deficit, or perhaps out of some sense of love or loyalty to the abuser. Ways must be devised for seniors to become their own best advocates in reporting this

regrettable misfortune that is touching the lives of too many of our elders.

Another obstacle encountered in completing this study was in obtaining accurate and concise statistical data describing elderly abuse in standard terminology consistent to each professional reporting information to the APS. Precision in documentation of the pertinent data by the professionals in the field would contain fewer gaps if universal terms and concepts were established. The poorly communicated information has a significant affect on the researchers' ability to generate reliable figures on the prevalence rate as well as the nature of the mistreatment being inflicted on the elderly population. Ross, Ross, and Ross-Carson (1985) reported that missing information is a significant contributing factor slowing down the process of gaining helpful insights for sound theory development on the abuse of the elderly. Thus, the extent of elder mistreatment will not be known until better ways have been established to identify the abused, more channels have been created for seniors to report the abuse, and nationally formulated operational definitions and concepts have been derived for documenting and reporting elderly abuse.

This problem was further compounded by the professionals who failed to consistently label incidents as non-family mediated or otherwise. This meant that pioneer

researchers were investigating elder abuse from an erroneous and biased point of view. What was evident in this study was that the abuser was usually a relative of the abused. In fact, abuse by those other than relatives occurred in only 15 cases.

Aside from the confusion in communication experienced by gerontology professionals on all levels, the overwhelming task is to reach the elderly parent who may be socially isolated and a victim of a climate of fear and dependency within which abuse often takes place. Finally, there is the abusive adult who is probably experiencing an overwhelming amount of stress from having to care for the elder, which, in combination with any number of personal problems, sets in motion the increased likelihood of violence and abuse. Where can the answer be found that will help combat this prevalent domestic problem resulting in elder mistreatment? For the time being, the response rests solely on third-party diagnosticians who are knowledgeable in elder abuse, can make assessments including detection, and report the abuse to prevent it recurrence.

Findings

This survey study revealed that of the 57 cases of elder abuse, physical violence was the most widespread form of mistreatment, followed by psychological abuse and self-

neglect. The sample of abused elders was drawn from approximately 741,300 elderly persons living in San Francisco County, which represents one for every 13,000 seniors reported in the total population in 1988. This rate is lower than was expected but is consistent with the nation's elderly population being subjected to abuse and neglect (Pearson, 1982). The conclusion that can be drawn from this survey is that abuse occurs within the ranks of seniors, but with only a small proportion of the total population of elders residing within San Francisco County. It should be noted, however, that although all 206 elder abuse cases reported to the APS during the study period represent less than 1% of the population of seniors in the community, a number of cases are probably not reported. These statistics may not represent a great number by many standards, but to the victim living daily with the threat of violence, it could mean continued pain, suffering, and even death. Therefore, without a doubt, the concern must still be with that minority of elders who remain outside institutional settings and continue to be victimized and abused.

This study showed that victims of elderly abuse tended to be 75 years of age or older. Usually these victims were white females who were living with a relative or one non-relative caregiver. However, others did live alone,

dispelling the notion that abuse does not occur when an elderly person is living independently. This study indicates that a vast majority of the victims had several limitations in physical and/or mental functioning and were dependent on their abusers for their physical and psychosocial support.

This study will be listed with those of other researchers whose data support these findings. The victims' characteristics included the following:

(a) inability to live independently (O'Malley et al., 1979; Wolf & Pillemer, 1984; Wolf, Godkin, & Pillemer, 1986), (b) physical frailty (Briley, 1979), (c) mental and/or physical impairment (Hirst & Miller, 1986), (d) advanced age (usually over 75) (Quinn & Tomita, 1986), and (e) multiple chronic disease disorders (Lau & Kosberg, 1979; Wolf et al., 1986). Of particular interest was that none of the victims reported the abuse directly to the APS agency.

Far less information was gathered from this survey on the abuser, but these data are of vital interest for elder abuse prevention. Contrary to the results reported by others investigating elder abuse (Lau & Kosberg, 1979; Pierce & Trotta, 1986), this study revealed that white male relatives over 50 years of age were most often the abusers. Many of the abusers were senior citizens. Research data of

Chen, Bell, Dolinsky, Doyle, and Dunn (1981) coincided with the findings of this study, which identified male family members most often as perpetrators of elder abuse.

A complete characteristics profile for the abusers was not the objective of this study, but other researchers examining elderly abuse have identified the following: (a) marked stress and fatigue (Anetzberger, 1987; Eastman, 1984), (b) financial difficulties (Falcioni, 1982; Quinn & Tomita, 1986), (c) unemployment (Anetzberger, 1987; Hickey & Douglass, 1981), (d) a history of being abused (Chen et al., 1981; Fulmer & Cahill, 1984), and (e) substance abuse (Falcioni, 1982). In at least two of the cases, the abuser had come to the attention of a case manager prior to the reported incident, but intervention had not been a viable option. The concern is that abuse in these cases and others could exist, and probably does, for extended periods of time without ever being reported by the professional or the elder. Differing views regarding causal factors responsible for elderly abuse within the domestic setting still prevail within the literature. The one view most gerontologists hold is that abuse will remain far-reaching into the community of elders until more fundamental knowledge regarding dynamics of elderly familial abuse can be defined and understood through causal and theoretical models derived from research data.

Since many cases of elder abuse go unreported because the victim is reluctant to contact legal agencies, it was noteworthy that abuse victims in the study were initially identified and reported by either federal, state, or private agency personnel within the county. Another study (O'Malley et al., 1979) indicated that families and victims seldom directly report abuse, and that in 70% of the cases it takes the active involvement of a third party to bring the issue to the attention of a professional or paraprofessional. Sengstock and Barrett (1986) noted that it is fairly common for elders to use a mediating agency instead of reporting the abuse directly to an APS. Consequently, in this study, social service personnel and a wide variety of other professionals were found to be the individuals most likely to report elder abuse. Additionally, in spite of efforts to protect or provide supportive services for the suspected victim, a few were found to have been discharged to the community setting because they refused assistance.

Conclusions

From this limited descriptive survey, elder abuse appears to be the result of a lack of knowledge or capacity to care for the older person by the caregiver related to:

- (a) internal stress of the caregiver who has to provide for an elderly person with severe mental or physical

impairments without adequate respite or support services; (b) external stress of the abuser, who often may be overwhelmed by his or her own emotional, physical, or financial problems and is exhibiting maladaptive coping behavior; and (c) the inadequacy of the establishment in the areas of expected knowledge, available response systems, manpower, or finances to sufficiently combat the abuse problem.

The elderly represent one of the fastest growing age groups in the county, with those older than 65 now representing approximately 25.5 million, or 11%, of the total population (Riffer, 1985). By the year 2040 it is estimated that the elderly will represent 21% of the total population (Riffer, 1985). These data support the unfortunate fact that out of approximately 1 million cases of abuse occurring each year, only 1 in 6 cases is ever reported (Pearson, 1982). Pearson (1982) postulated that as many as 4% of the nation's elderly population are abuse victims, and by all the available indicators it can only be speculated that abuse of all types will continue and increase in the future. This is by virtue of the fact that the numbers of seniors joining the ranks are also growing. If these projections are valid, frail white females over the age of 70 years will constitute the largest proportion of the reported and unreported cases of elderly abuse

throughout the state and the nation. Males, specifically sons, will be implicated more often than females or other relatives who may be caring for the elderly victim.

It must also be noted that the majority of victims in this study had some sort of impairment that contributed to their being abused. Therefore, health professionals in the field must pay close attention to families, especially care custodians, in the community who have taken responsibility for the care of an elderly dependent person with high-risk characteristics. It can also be expected that the scope of the problem will increase as: (a) public and professional awareness and knowledge intensifies and (b) existing laws are enforced and new ones are passed or amended that will serve to deter or lessen the prevalence rate.

Consequently, with the advent of better resource linkages, support services, alternative living arrangements, and improvements in both education and the legal system, the scope and nature of elder abuse will then decrease.

On the other hand, research is lagging and expert knowledge of elderly abuse is accumulating at a much slower pace, as evidenced by the fact that over an approximately 10-year span, only 32 studies have been done on elderly abuse (Hudson, 1989). The foremost inquiry still being made by those in the field is, how will elderly abuse be defined?

Recommendations

The solution to the problem of elder abuse is extremely complex and multifaceted. However, there are some obvious starting points. One of the primary steps to be taken is to increase the level of awareness of elder abuse. Education about the nature and causes of such mistreatment is imperative for both the general public and those professionals caring for this unique population. The idea of aging should be given new meaning, representing a positive era in one's life rather than the present negative association. If the concept that reinforces the idea of the intrinsic value of each individual, regardless of age, race, or sex, could be incorporated into the mainstreams of this society, then mind sets portraying the aged in a more favorable light could become a natural way of life. The elderly must be valued, and this should be accomplished in such a way that seniors are made to feel their own self-worth and actively participate in the efforts of remaining productive. The benefits for society could be enormous. The media could facilitate this educational endeavor toward viewing old age in a positive way and help erase numerous myths about the aging process. Elder abuse will continue as long as negative attitudes toward the aged are allowed to proliferate within our civilization.

Cultural stereotyping of the aged contributes greatly to the ongoing incidence of elder abuse. Public education is essential. Despite the aforementioned limitations, many of the gaps are being filled as a result of increased knowledge from research data and education of the public and professionals. Improved response support systems made available by funding specifically targeted for the prevention and intervention of aged abuse in the community will also help in curtailing the physical, economical, and emotional harm to seniors.

Secondly, it is imperative that professionals be educated on making determinations to identify elders who are at the greatest risk of mistreatment. Professionals from the numerous private and public sectors must be given the opportunity to learn and use the appropriate screening procedures, and must be given tools in order to make accurate assessments that will aid in detection and intervention. An educational program concerned with the detection and prevention of elder abuse might include assessment tools such as those developed by Ferguson and Beck (1983), Tomita (1982), or Kosberg (1988). Any assessment done when abuse is suspected should include attention to high-risk indicators for the aged person, caregiver, and family support system. Such assessments will not eliminate the problem, but with education,

awareness, detection protocols, and available alternative support systems within the community, the elderly can expect to live with respect and dignity, free from mistreatment.

Thirdly, more effective protective service policies and practices for the aged must be enacted. Mandatory reporting laws should be established in all states, with federal guidelines developed to establish uniform statutes for dealing with elder abuse. These laws would be administered through a predetermined agency having a designated purpose, scope, reporting requirements, and mandated investigation or service component. Universal operational definitions categorizing the forms of abuse would become standardized from state to state so that identical concepts would be used and understood when describing similar phenomena related to elder abuse. The elderly must also have viable alternatives to remaining in an abusive situation, which might include: (a) better access to service providers, (b) more comprehensive and flexible services for support by service providers, (c) abuse telephone hotlines other than those offered by law enforcement agencies, (d) improved case management strategies that teach caregivers techniques for caring for the aged, and (e) greater opportunity to participate in their own living arrangements.

Lastly, research support is needed to formulate models, definitions, and protocols for the detection and effective treatment of elder abuse by gerontology professionals. Legislative funding needs to be harnessed to help provide the manpower for practice and educational programs for professionals as well as for the community in general. Even though 96% of the elderly population of any community are completely self-sufficient and probably not abused (Fulmer et al., 1987), this problem still exists for the remaining scores of others who continue to experience frequent physical, psychological, and material attacks. For the health professional working on this problem, this means greater energy must be expended to decrease the incidence of elder abuse.

Further research is needed to include larger direct samples of caregivers, seniors, or significant others, as opposed to samples from professional reports or secondary sources. Additional research is needed to explore and acquire knowledge about the abusive caregiver and the family dynamics that appear to foster such violence. Major areas in need of investigation emphasized throughout this study are incidence and prevalence studies, theory testing and building, and development of a universal definitive language for elder abuse. Other research studies should be done with longitudinal and comparison-group designs to

yield fresh information for service providers, especially health providers, the gatekeepers who are given the responsibility of protecting the elderly.

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APPENDIXES

APPENDIX A

Letter to Department of Social Services

April 10, 1989

Dear _____:

I am a master's candidate in the Department of Nursing at San Jose State University, presently working toward a Master of Science degree in Nursing, focusing on gerontology. As partial fulfillment of the requirement for the degree it is necessary to complete a research study. I am writing a thesis on elderly mistreatment, its prevalence, and nature, as seen in the urban community senior dwellers. The most recent topic of discussion and widespread concern of many geriatric health care clinicians has been focused on the issues and unanswered questions surrounding possible mistreatment of the contemporary elderly citizens. From the limited information available it would appear, at first glance, that education of the health care professionals in detection techniques is needed and would provide an invaluable intervention strategy for safeguarding one of the most vulnerable groups within our present society. The object of this research study will seek to provide some information usable for the health care professionals working within the community who must become more knowledgeable and skillful in the recognition and case-finding process.

I have spoken with _____ regarding my proposal objective in utilizing statistical data from the Agency's closed case management files, and he has agreed to assist me in this matter. Any data used will be personally screened and handled by _____ so that complete confidentiality will be maintained and actual names of the persons involved, inclusive of individual clients, will remain anonymous.

Should you have further questions regarding this thesis proposal, I am available at any time to provide additional information. I can be reached at _____. Complaints or any other inquiries may be directed to San Jose State University Nursing Department, Virgil Parsons, Chair, or Serena Stanford at (408) 924-2480.

Thank you for your consideration.

Sincerely yours,

Gwendolyn Brown, R.N.

APPENDIX B
Letter to APS Director

To whom it may concern:

I am a master's candidate in the Department of Nursing at San Jose State University, presently working toward a Master of Science degree in Nursing, focusing on gerontology. As partial fulfillment of the requirement for the degree it is necessary to complete a research study. I am writing a thesis on elderly mistreatment, its prevalence, and nature, as seen in the urban community senior dwellers. The object of this research study will be to corroborate or contrast statistical data obtained by another researcher looking at this same social problem.

The agency supervisor has been requested to assist me in obtaining the statistics for completion of this study, and he has agreed. Collection of data will be accomplished with the use of the attached survey tool. Any of the data used will be confidentially coded, and actual names of the persons involved, inclusive of individual clients, will remain anonymous. Should you have any questions about this research proposal, I am available at any time to provide additional information. I can be reached at _____ . A final copy of this study will be available in the library at San Jose State University upon completion of my thesis.

Thank you for your assistance.

Permission is granted to Gwendolyn Brown to conduct this research study at this agency with the assistance of the facility supervisor.

Signature

Date

Title

APPENDIX C
Abuse Report Form

Abuse Report Form

Case No. _____

I. Information on Victim

a. Age _____ Sex _____ Ethnic Group _____

b. Responsible Caretaker (resides at same address):

_____ Son
_____ Daughter
_____ Spouse
_____ Care Custodian
_____ Other: _____

c. Degree of Physical/Mental Impairment:

_____ Developmentally Disabled
_____ Mentally Disabled
_____ Physically Handicapped
_____ Brain Impaired
_____ Frail/Elderly (Functionally Impaired)
_____ Hospitalized Adult

II. Type of Abuse (check one or more)

a. Physical/Medical

_____ Assault/Battery
_____ Constraint or Deprivation
_____ Sexual
_____ Medication Violation
_____ Lack of Medical Care
_____ Other: _____

b. Self-Inflicted

_____ Neglect
_____ Substance Abuse
_____ Suicide
_____ Other: _____

c. Psychological

_____ Verbal Assault
_____ Threat
_____ Fear
_____ Isolation

d. Material

☐ Threat to money or property
☐ Misuse of money or property
☐ Fiduciary

e. Violation of Rights

☐ Forced from home
☐ Forced from nursing home

III. Reporting Source (How did you get this case?)

☐ Self-Report
☐ Private medical doctor
☐ Hospital or clinic
☐ Police
☐ Public social service agency
☐ Public health agency
☐ Other: _____

IV. Information on Perpetrator

a. Age _____ Sex _____ Ethnic Group _____

b. Relationship to Victim

☐ Health practitioner or care custodian
(specify): _____
☐ Spouse
☐ Son
☐ Daughter
☐ Other: _____
☐ Unknown

V. Action Taken

☐ Victim refused service
☐ Resolved; no serviced needed
☐ Referred to other agency for placement
☐ APS