ABSTRACT

THERAPEUTIC NEEDS OF OLDER ADULT SURVIVORS OF ELDER ABUSE: PERSPECTIVES OF CLINICIANS

By

Catherine E. Adkins

May 2015

The purpose of this qualitative study was to explore, from the perspectives of clinicians, the therapeutic techniques they have found to be effective in helping older adults recover from elder abuse. The researcher developed the interview guide. A total of 12 clinicians, who had experience working with survivors of elder abuse in a therapeutic setting, were interviewed.

The results indicated that clinicians saw similar symptoms, including depression, anxiety, trauma, and fear. Methods for addressing those symptoms included cognitive-based therapy, active listening, life reviews, and making referrals. Therapeutic involvement with the family was low, but when used included education and active listening. Lastly, there was a high demand from clinicians for prevention efforts and education regarding elder abuse.

More research is needed on effective interventions for helping older adults recover from elder abuse.

THERAPEUTIC NEEDS OF OLDER ADULT SURVIVORS OF ELDER ABUSE: PERSPECTIVES OF CLINICIANS

A THESIS

Presented to the School of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

Committee Members:
Molly Ranney, Ph.D. (chair)
Marilyn Potts, Ph.D.
Jo Brocato, Ph.D.

College Designee:
Nancy Meyer-Adams, Ph.D.

By Catherine E. Adkins

B.A., 2009, California State University, Long Beach

May 2015

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

ACKNOWLEDGEMENTS

I would like to thank all of the people who participated in this study, those who guided me through the research, and those who supported me personally in my goals of conducting this study as part of my educational process.

This study could not have been possible without the generous participants who donated their time and knowledge to further research on this sensitive subject. I truly appreciate your involvement, enthusiasm, and willingness to share your experiences. I have never met so many individuals who are collectively passionate about older adults and ensuring they have the respect and dignity they deserve as they age.

Next, I would like to thank my thesis advisor, Dr. Ranney. Without your guidance, expertise, and support, this study would not have happened. Thank you for all your time and knowledge.

Last but not least, I would like to thank my boyfriend, Dirian Moore, and my family. Without your endless support, love, and ability to see the positive in all situations, I would not be where I am today. Through all the challenges and successes, your encouragement and faith in me has never faltered and has made me who I am today. I am truly blessed to have such a supportive boyfriend and large, loving family from coast to coast.

Thank you.

TABLE OF CONTENTS

CHAPTER Page

TABLES

CHAPTER 1

INTRODUCTION

Statement of the Problem

Studies have shown that about 1 in 10 older adults in the United States have experienced some type of abuse within 1 year (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009; Laumann, Leitsch, & Waite, 2008). Elder abuse is a growing issue that has traditionally been under-reported and stigmatized (National Center on Elder Abuse [NCEA], 2014a). Professionals who work with elder abuse survivors are in a unique position to build rapport and draw upon the strengths of the victims to assist in their recovery. They are also able to recognize patterns in behaviors and traits common to those who have successfully overcome this challenging and potentially life-threatening event.

Elder abuse does not discriminate; it is surely a world-wide issue but there is little information on the extent of elder abuse, especially in developing countries (World Health Organization [WHO], 2014). It is impossible to know exactly how many elder abuse survivors and victims exist since this problem is often ignored and still considered a private matter (WHO, 2014). Furthermore, there are no federal regulations or an agreed upon national definition in the United States for elder abuse; this lack of cohesion makes research on the problem challenging and produces varying results (Anetzberger, 2012).

In Los Angeles County, California, the number of inconclusive elder abuse cases significantly outnumbered the number of confirmed cases; there were 1,629 inconclusive

cases, 478 confirmed cases, and only 24 cases of unfounded elder abuse (California Department of Social Services [DSS], 2014). The numbers are less drastic in Orange County, California. In September 2014, there were 183 confirmed cases, 148 inconclusive cases, and only 11 cases of unfounded elder abuse (DSS, 2014).

The WHO (2011) reported that victims of elder abuse are at risk for depression and anxiety. The Centers for Disease Control and Prevention (CDC; 2014) reported that potential effects include increased risk for anxiety, learned helplessness, and posttraumatic stress syndrome (PTSD). While some research on the impact of abuse on the psychological well-being of older adults has been done, little research has been conducted on the therapeutic techniques that are used by clinicians to help older adults recover.

Purpose of the Study

From the perspective of clinicians, the purpose of this study was to examine therapeutic techniques they have found to be effective in helping older adults recover from the emotional and psychological effects of elder abuse. This study addressed the following questions:

1. What are the primary clinical symptoms that older adults who have experienced elder abuse present in therapy?

2. What therapeutic interventions do clinicians use to help older adults recover from elder abuse?

3. To what extent do clinicians interact and provide therapeutic interventions to the family members or support networks of survivors?

4. What can be done to prevent elder abuse in the future?

Definitions of Terms

Abandonment: The willful desertion of an elderly person by a caregiver or other responsible person (CDC, 2014).

Activities of daily living (ADL): Activities such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet (CDC, 2013).

Financial abuse or exploitation: The unauthorized or improper use of the resources of an elder for monetary or personal benefit, profit, or gain. Examples include forgery, misuse, or theft of money or possessions; use of coercion or deception to surrender finances or property; and improper use of guardianship or power of attorney (CDC, 2014).

Physical abuse: This occurs when an elder is injured (e.g., scratched, bitten, slapped, pushed, hit, burned, etc.), assaulted or threatened with a weapon (e.g., knife, gun, or other object), or inappropriately restrained (CDC, 2014).

Neglect: The failure or refusal of a caregiver or other responsible person to provide for an elder's basic physical, emotional, or social needs, or the failure to protect him or her from harm. Examples include not providing adequate nutrition, hygiene, clothing, shelter, or access to necessary health care, as well as failure to prevent exposure to unsafe activities and environments (CDC, 2014).

Psychological or emotional Abuse: This occurs when an elder experiences trauma after exposure to threatening acts or coercive tactics. Examples include humiliation or embarrassment, controlling behavior (e.g., prohibiting or limiting access to transportation, telephone, money, or other resources), social isolation, disregarding or trivializing needs, or damaging or destroying property (CDC, 2014).

Sexual abuse or abusive sexual contact: This occurs when there is any sexual contact against an elder's will. This includes acts in which the elder is unable to understand the act or is unable to communicate. Abusive sexual contact is defined as intentional touching (either directly or through the clothing) of the genitalia, anus, groin, breast, mouth, inner thigh, or buttocks (CDC, 2014).

Older population: This includes individuals aged 65 and older (Administration on Aging, 2011).

Social Work and Multicultural Relevance

As the older adult population continues to expand in the United States, the prevalence of elder abuse will also increase (American Psychological Association, 2014a). It is important for all clinicians to be aware of the signs, symptoms, and responses to help this population. In the field of social work, it inevitable that one will encounter older adults in one's work whether it is a caregiver for a grandchild, an aging parent, or older adults in general. Elder abuse can affect everyone no matter his or her race, culture, economic status, gender, or age. This is a potentially global epidemic evident developed countries and in need of further research in developing countries (WHO, 2014). Simply recognizing the abuse is not enough. It is important that social workers and other clinicians know how to respond and effectively provide treatment to survivors of abuse while taking into consideration cultural factors. For the purpose of this study, cultural factors common to Los Angeles and Orange County, California, will be the main focus of discussion. The multicultural aspect will include elder mistreatment as it impacts older adults who identify as Latino or Hispanic, African American, Asian, or LGBT (lesbian, gay, bisexual, transgendered).

CHAPTER 2

LITERATURE REVIEW

Demography: Growing Population

The number of older adults in America is on the rise. According to the U.S. Census Bureau (2010), the number of older adults continues to increase and they are living longer than any other population before them. This same report also showed that people who are 65 years or older are the fastest growing portion of the total population (U.S. Census Bureau, 2010). From 2000 to 2010, this segment of those ages 65 and older increased by 15.1%, compared to the total population increase of only 9.7% (U.S. Census Bureau, 2010). Furthermore, the fastest growth within this segment consisted of those aged 85 to 94 years old; this group increased by almost 30%. Individuals who are aged 95 and older had a similar growth rate of 25.9% (U.S. Census Bureau, 2010). These numbers will become greater since the first wave of baby boomers turned 65 in 2011 (U.S. Census Bureau, 2010). The baby boomers are comprised of people who were born in mid-1946 to 1964 (U.S. Census Bureau, 2010). Only 3.1% of the population over the age of 65 is living in nursing facilities, leaving 96.9% of older adults residing primarily in the community (U.S. Census Bureau, 2008a).

Future projections show a dramatic increase of older adults in the United States; by 2050, the number of those aged 65 and older will double and that of those who are 85 years and older will triple (U.S. Census Bureau, 2008a). The group who will experience

the highest increase consists of those who are 100 years and older. This group will become 7 times larger (U.S. Census Bureau, 2008a). While the population of older adults has increased over the entire county, the West had the fastest growth rate of those 65 years and older and of those 85 years and older (Werner, 2011). Within California, the number of older adults ages 65 and older increased by 18% and those ages 85 and older increased by 41.2% (Werner, 2011).

Incidence and Prevalence of Elder Abuse

Acierno et al. (2009) reported that 11% of elders have experienced some type of abuse. Elder abuse does not discriminate; it is seen all over the world but has only been researched in developed countries (WHO, 2014). Due to increased vulnerability, those who are 80 years and older are at the highest risk for elder abuse and neglect (NCEA, 1998). A study of 676 individuals ages 75 and older determined that suspected abuse of people in this age bracket ranged from 25.8% to 32.8% (Garre-Olmo et al., 2009). This is especially important since this is the fastest growing segment of older adults in the United States (U.S. Census Bureau, 2010).

In California, there many cases of elder abuse that are reported but are unfounded (DSS, 2014). According to the September 2014 report from the DSS in California, there were 2,126 cases of confirmed elder abuse perpetrated by others and 3,262 cases that were determined to be inconclusive. This number indicates that there may be many more cases of elder abuse than those which were confirmed. Of the confirmed cases of abuse perpetrated by others, most (n = 481) were psychological abuse, followed by financial abuse (n = 469), physical (n = 253), neglect (n = 201), isolation or abandonment (n = 40) and sexual abuse (n = 5).

What is Elder Abuse?

According to the CDC (2014), elder abuse is any abuse and neglect of persons age 60 and older by a caregiver or another person in a relationship involving an expectation of trust. The types of elder abuse included for the purpose of this study are physical, emotional or psychological (used interchangeably), sexual, financial exploitation, neglect, and self-neglect.

Studies have shown that it is important to examine the types of abuse individually, since they have different risk factors (Garre-Olmo et al., 2009; Jackson & Hafemeister, 2011). Therefore, this chapter examines each type of abuse individually; the risk factors, as well as the common signs and symptoms for each particular type of abuse will be discussed.

Financial Abuse or Exploitation

Financial abuse or exploitation is the unauthorized or improper use of the resources of an elder for monetary or personal benefit, profit, or gain (CDC, 2014). This type of mistreatment has the highest past-year prevalence rate of 5.2% of older adults (Acierno et al., 2009). Financial mistreatment was reported by 6.5% of older adults who experienced this at some time during their lifetime and was perpetuated by a stranger (Acierno et al., 2009). The common signs of potential financial exploitation include large withdrawals from bank accounts, switching accounts, or signatures on checks that do not match the older adult's signature (Muehlbauer & Crane, 2006). People who are aged 85 and older had a higher incidence of financial abuse compared to those aged 75 to 85 (Garre-Olmo et al., 2009). Additionally, those who reported being single were found to

experience a higher rate of financial abuse compared to those who were married or widowed (Garre-Olmo et al., 2009).

Emotional or Psychological Abuse

Emotional or psychological abuse occurs when an elder experiences trauma after exposure to threatening acts or coercive tactics. Examples include humiliation or embarrassment; controlling behavior, social isolation, disregarding or trivializing needs, or damaging or destroying property (CDC, 2014). According to the National Elder Mistreatment Study (Acierno, et al., 2009), this type of mistreatment had a past-year prevalence rate of 4.6% among the older adults who were surveyed. The common signs of potential emotional abuse include an unresponsive attitude, abnormal fearful or suspicious behavior, lack of interest in social contacts, or an avoidance of others (Muehlbauer & Crane, 2006).

Previous research has found that depressive symptoms are also an indicator of psychological abuse (Garre-Olmo et al., 2009). Depressive symptoms include a depressed mood, lack of interest in activities, fatigue or loss of energy every day, feelings of worthlessness or excessive guilt, reduced ability to think or concentrate, or recurrent thoughts of death or suicide (American Psychiatric Association, 2013). Furthermore, those who had very few social supports were 3 times more likely to suffer this form of abuse (Acierno et al., 2009) and of the older adults who lived alone, 28.4% reported suspected psychosocial abuse (Garre-Olmo et al., 2009). Older adults who needed assistance with his or her ADL and those who had prior traumatic experiences were 2 times more likely to experience emotional abuse compared to those who did not have those risk factors (Acierno et al., 2009).

The National Elder Mistreatment Study (Acierno, et al., 2009) also found that the victims knew the perpetrators 82% of the time; the perpetrators included spouses, children, grandchildren, other relatives, or acquaintances. About one fifth of the perpetrators who were known to the victims were abusing substances near the time of the mistreatment and similarly, about one fifth had some form of mental illness (Acierno et al., 2009). Lastly, this study indicates nearly half of the perpetrators were socially isolated and unemployed.

Physical Abuse

Physical abuse occurs when an elder is injured, assaulted or threatened with a weapon, or inappropriately restrained (CDC, 2014). This type of mistreatment has a past-year prevalence rate of 1.6% of older adults (Acierno et al., 2009). Physical abuse can be especially dangerous to the elderly due to their bones being more brittle and their recovery time much longer, so even minor injuries may lead to permanent disability or death (WHO, 2014).

Common signs of potential physical abuse include bruises around the arms or neck, repeated unexplained injuries, dismissive attitude when asked about injuries, or refusal to go to the same emergency department for repeated injuries (Muehlbauer & Crane, 2006). Elders who have few social supports and are 70 or younger have the highest risk of experiencing physical abuse compared to other older adults (Acierno et al., 2009). A family member or acquaintance was the perpetrator in 95% of the cases while strangers accounted for only 3% of incidents (Acierno et al., 2009). These perpetrators were often socially dysfunctional and struggled in their employment (Acierno et al., 2009). However, this may not always be the case. In a study of adults (n = 452) with

family members in a nursing home, 24.3% reported at least one instance of physical abuse of their family member by nursing home staff (Schiamberg et al., 2012).

Sexual Abuse

Sexual abuse is any sexual contact against an elder's will. This includes acts in which the elder is unable to understand the act or is unable to communicate. Abusive sexual contact is defined as intentional touching of the genitalia, anus, groin, breast, mouth, inner thigh, or buttocks (CDC, 2014). This type of mistreatment has the lowest past-year prevalence rate of 0.6% and a lifetime prevalence rate of 7% of older adults (Acierno et al., 2009). Common symptoms of possible sexual abuse include unexplained vaginal or anal bleeding, torn or bloody underwear, bruises on breasts, or vaginal infections (Muehlbauer & Crane, 2006). The perpetrators were family members in 52% of the assaults while strangers accounted for only 3% of assaults (Acierno et al., 2009). Of the known perpetrators, 28.2% had substance use problems, 22.9% were unemployed, and 53.1% were socially isolated (Acierno et al., 2009).

Sexual abuse also affects men and women who live in nursing homes with the perpetrators mostly being other residents (Teaster et al., 2007; Teaster & Roberto, 2003). Teaster and Roberto (2003) conducted a study of Adult Protective Services data of sexual abuse; 50 cases were substantiated against women and in only 3 cases was the offender convicted. The perpetrators in this study were all male, 70 years of age or older, and also residents in the nursing home (Teaster & Roberto, 2003). In a study of sexual abuse of men in nursing homes there were six confirmed cases; all the victims were males and the perpetrators were mostly other residents in the nursing home (Teaster et al., 2007; Teaster & Roberto, 2003).

Neglect and Self-Neglect

Neglect is the failure or refusal of a caregiver or other responsible person to provide for an elder's basic physical, emotional, or social needs or failure to protect them from harm. Examples include not providing adequate nutrition, hygiene, clothing, shelter, or access to necessary health care or failure to prevent exposure to unsafe activities and environments (CDC, 2014). This type of mistreatment had a past-year prevalence rate of 5.1% of older adults (Acierno et al., 2009). The common signs of neglect include weight loss, sunken eyes, or bedsores (Muehlbauer & Crane, 2006). Neglect and self-neglect are particularly challenging because according to Adult Protective Services reports, these victims are 5 times more likely to refuse help than those suffering from other forms of abuse (Gainey, Payne, & Kropf, 2010).

General High-Risk Factors

While each type of abuse has its own specific risk factors, there are also symptoms and high-risk characteristics that can signal multiple types of abuse. According to the National Elder Mistreatment Study (Acierno et al., 2009), elders (n = 5,777) who reported abuse, often had similar characteristics or risks factors including low social supports, they required assistance with ADLs, and they had prior traumatic experiences. Other characteristics from the same study included the victims being in a non-White racial group, having lower income, and poor health. Additional risk factors for victims include a diagnosis of dementia, being female, and cohabitating with others (WHO, 2014). It is recommended that professionals are especially attentive to individuals who are 85 years and older; who live with family members who are not their

spouse; and who may be socially isolated, struggle with incontinence, display symptoms of cognitive decline, and express depressive symptoms (Garre-Olmo et al., 2009).

A person who has dementia or a physical disability is at a higher risk for abuse because of the symptoms associated with the disease. According to the Alzheimer's Association (2014), dementia is a general term that describes a group of symptoms such as loss of memory, judgment, language, complex motor skills, and other intellectual functions. This is caused by the permanent damage or death of the brain's nerve cells, or neurons. The most common form of dementia is Alzheimer's disease (Alzheimer's Association, 2014). According to the Alzheimer's Association, there are 5 million Americans living with Alzheimer's disease and 1 in 3 older adults will die from some form of dementia. The caregiving duties for someone with this disease are very demanding. Almost 60% of caregivers reported the emotional stress of caregiving to be high or very high and more than one third of caregivers reported symptoms of depression (Alzheimer's Association, 2014). In a recent study of 129 people diagnosed with dementia and their caregivers, maltreatment was identified in 47.3% of cases (Wiglesworth et al., 2010).

Reasons for Under-Reporting

Even though there are thousands of reports each month in California, elder abuse still remains under-reported for various reasons. Only 8% of the past year incidents of elder abuse were reported to law enforcement agencies (Acierno et al., 2009). There are various reasons the reporting of elder abuse is so low. According to the NCEA (2013b), victims may refuse to report the abuse due to fear of retaliation from the abuser, a physical or mental inability to make a report, or they do not want the abuser, most likely

a family member, to get into trouble. Other reasons for underreporting include the victim's reduced mental capacity to understand his or her rights, a lack of knowledge of the law, or cultural differences that prevent the older adult from recognizing elder abuse is occurring (Donovan & Regehr, 2010). Cultural differences may prevent reporting due to immigration status or cultural beliefs of preserving the family unit and avoiding shame; a report of elder abuse within the family may bring shame to the family within the community (NCEA, 2013a).

Perpetrators of Abuse

The perpetrators of elder abuse are most likely to be someone the elder knows. According to Laumann et al. (2008), of the 3,005 respondents interviewed, 57% of those who have experienced elder abuse reported the perpetrator to be someone other than a close family member. This percentage is lower than the information gathered from the National Elder Mistreatment Study (Acierno et al., 2009). Of the people who reported abuse, the perpetrators were a family member 76% of the time. The American Psychological Association (2014a) supports this research, indicating that most abusers are the adult children of elders or other family and spouses.

Perpetrators have various reasons for the abuse they commit against elders. Many perpetrators believe the older adult's money is payment for their services, they experience stress from the duties of caregiving, seek revenge that is motivated from years of childhood abuse, or they may see the older adult as vulnerable and able to be exploited (Frolik & Whitton, 2010). There may also be alcohol or substance addiction on the part of the abuser that motivates him or her to take advantage of the older adult for money or lash out physically or verbally (Frolik & Whitton, 2010). The specific type of abuse an

older adult is suffering often is associated with specific traits of the abuser (Acierno et al., 2009). For example, the perpetrators of physical abuse were more likely to be abusing substances and have mental health problems as compared to the perpetrators of emotional abuse (Acierno et al., 2009). In general, perpetrators have high unemployment rates, increased rates of substance abuse, and are more likely to suffer from mental health problems compared to the general population (Acierno et al., 2009).

Protecting Older Adults

Role of Adult Protective Services

In the late 1970s, Congress became aware of "Granny Battering" and implemented federal protections for adults and older adults (National Research Council, 2003). Burston (1975) was one of the first to write about "granny battering" and highlighted the need for increased awareness of elderly people who are purposefully battered by their relatives. Burston emphasized the need for general practitioners, nurses, and social workers to be aware of this when caring for the elderly. Baker (1981) also wrote about the physical and emotional maltreatment of older adults by family members, society, and the medical profession. Baker described how societal values, family violence and neglect, and the degrading treatment from the medical profession impact aging and contribute to elder abuse. Even though Baker focused primarily on physical abuse and neglect, this was one of the early articles to articulate the struggles older adults faced and laid the groundwork for the expanded definition to include emotional, financial, and sexual abuse.

In response to elder abuse and the need to protect vulnerable older adults, Adult Protective Services was formed. According to the National Adult Protective Services

Association (NAPSA), it was not until 1985 that 46 states had an office with the responsibility to provide Adult Protective Services. It was not until 1991 that there were mandatory reporting requirements in only 42 states (NAPSA, 2014a). Mandatory reporting requirements apply to anyone who provides a service to seniors or adults with disabilities. If during their employment responsibilities providers who serve seniors become aware of or suspect abuse or neglect, they are then required to make a report to the local Adult Protective Services agency (NAPSA, 2014a).

Currently, Adult Protective Services is operated by local states and counties nationwide to serve older adults and adults with disabilities in need of assistance (NAPSA, 2014a). In California, Adult Protective Services is provided in all 58 counties; each county investigates reports of abuse occurring in private homes, hotels, hospitals, or health clinics (DSS, 2007). Services are available to anyone regardless of income level or location; Adult Protective Services investigates reports of abuse or neglect that occurs in private homes, hospitals, and health clinics (DSS, 2007). For reported abuse occurring in long-term care facilities, nursing homes, or residential facilities, the Office of Ombudsman is the responsible investigating agency (DSS, 2007).

When a report of suspected elder abuse occurs, it is often an Adult Protective Services worker or ombudsman who is the first responder to the case of abuse, neglect, and exploitation. The worker collaborates as part of an interdisciplinary team such as medical personnel, firefighters, and police officers (NAPSA, 2014a). The goal of the worker is to provide an accurate assessment of each person's needs and develop a service plan to ensure that the person is able to maintain his or her safety, health, and independence (NAPSA, 2014a). The Adult Protective Services workers in California

accomplish this task by providing services including advocacy, alternative placements, counseling, financial assistance, and conservatorship (DSS, 2007).

Legal Protection

Legal protections for victims of elder abuse in California include mandatory reporting of suspected abuse or neglect and prosecution of the perpetrator. According to the California Welfare and Institutions Code (1986) section 15630 (a) a mandated reporter is anyone "who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation". This definition includes employees working in health administration, medical personnel, clergy members, employees of financial institutions, social workers, and law enforcement personnel. When professionals witness, reasonably suspect, or have been told by an elder of abuse occurring, they are required by law to report the abuse or suspected abuse immediately or as soon as practically possible to the local law enforcement or Adult Protective Services agency (CA Welf. & Inst. Code, 1986, sec.15630). Failure to report abuse or suspected abuse may result in legal penalties of up to 6 months in jail, a $1,000 fine, or both (CA Welf. & Inst. Code, 1986, sec. 15630). If a person is not a mandated reporter, but has witnessed or reasonably suspects abuse of an elder, he or she may also report the incident to the local law enforcement or Adult Protective Services agency (CA Welf. & Inst. Code, 1986, sec. 15630).

Once a report has been made, the legal protection for older adults who are victims of elder abuse are covered by California Penal Code, Section 368 (Crimes Against Elders, 2010). This law provides special protection for adults ages 65 and older because they may be confused, on various medications, be mentally or physically impaired,

and/or incompetent, leading to a situation where they are unable to protect themselves. According to California Penal Code section 368.5, the county or state law enforcement agency is responsible for investigating crimes against older adults in the community and may work in conjunction with the local Adult Protective Services agency (Crimes Against Elders, 2010). This law states that if a caregiver perpetrates or knowingly allows the physical or mental suffering of an older adult, he or she they may face up to 1 year in a county jail, be fined up to $6,000, be sentenced to both jail time and fines, or serve time in state jail for 2 to 4 years. If it is determined that the abuse caused the death of the elderly individual, then the abuser can face up to 5 years in jail if the victim is 70 years or younger and up to 7 years if the victim is 70 years or older (Crimes Against Elders, 2010). If the perpetrator is found guilty of fraud, identity theft, or embezzlement, the most serious consequence the perpetrator may face is a fine up to $2,500 or up to a year in prison (Crimes Against Elders, 2010).

Clinical Symptoms Experienced by Survivors of Elder Abuse

There has been limited research on the behavioral, social, and emotional effects of elder abuse; most studies of the effects of elder abuse focus on mortality and economic loss (Anetzberger, 2012). The WHO (2014) reported that victims of elder abuse are at risk for depression and psychological distress. The CDC (2010) also stated that the effects include increase risk for anxiety, learned helplessness, and PTSD. Prolonged abusive situations are frequently traumatic for the victim and not only may result in PTSD but may also have physical and psychological effects that may lead to self-destructive behavior (Papadopoulos & La Fontaine, 2000).

Pillemer and Prescot (1988) conducted one of the early studies of the psychological effects of elder abuse. This study showed that people who reported a history of abuse displayed much higher levels of depression compared to those who did not report a history of abuse. Another early study conducted by Comijis, Pennix, Knipscheer, and Van Tilburg (1999) found that elderly victims (n = 77) who reported verbal, physical, or financial mistreatment showed higher signs of psychological distress compared to the control group of 147 of people who did not report prior abuse. This study defined psychological distress as a higher dependency, a reduced confidence level in their abilities, and a passive reaction to situations.

There are two types of abuse that are generally the least prevalent: sexual and physical mistreatment. Sexual mistreatment accounts for less than 1% of past-year prevalence and physical mistreatment accounts for 1.6% of past-year prevalence (Acierno et al., 2009). Yet, research shows that the clinical symptoms of these two types of abuse are profound. Older women with a history of physical or sexual abuse were more likely to suffer from substance use disorders, depression, and PTSD (Cook, Dinnen, & O'Donnell, 2011). According to Teitelman (2006), older sexual abuse victims may have sudden emotional changes expressed as anxiety, depression, withdraw, or hyper-vigilance, and agitation. The medical conditions of sexual abuse victims may be exacerbated, especially with memory or attention problems (Teitelman, 2006). Family members may begin to display signs such as guilt, shame, or sorrow (Teitelman, 2006). Older victims of sexual abuse often have emotional trauma that is difficult to detect by observation alone. Furthermore, with older adults it is almost impossible to determine

whether the trauma is current or from past experiences possibly dating back to childhood (Teitelman, 2006).

In addition to psychological effects, it should be noted that there are physical effects as well for all types of abuse (CDC, 2010). These include sleep disturbances, nutrition and hydration issues, welts and wounds, worsening of pre-existing conditions, and premature death (CDC, 2010). Other physical effects include minor scratches, bruises, broken bones, and head injuries at times leading to lasting disability (WHO, 2014). Survivors of sexual or interpersonal violence may also display bruising on the breasts and genital area (Teitelman, 2006). With these physical and emotional effects, it not surprising that victims of elder abuse and self-neglect were found to have increased mortality rates after abuse compared to those who did not report previous abuse (Dong et al., 2009).

Interventions Effective for Survivors of Elder Abuse

It is important to emphasize that each case of abuse is unique and is a combination of the nature and duration of abuse, the accessibility of resources, the coping abilities of the individual, his or her current level of physical and mental health, and the meaning of his or her experiences (Papadopoulos & La Fontaine, 2000). Even after years of elder abuse, interventions in the research are scarce compared to information on prevention and recognizing signs of abuse (Wolf, 2000). Based on a review of previous research, Wolf (2000) found that many of the early studies of the emotional consequences of abuse were designed to be cross-sectional so it was impossible to determine whether conditions existed before the abuse or were a direct result of the abuse. Additionally, learned helplessness, isolation, guilt, shame, fear, anxiety, and PTSD have been shown to

be common effects but the validity and extent of these ailments need further research (Wolf, 2000).

Although there are many areas in need of further research, what is known is that elder abuse is happening and survivors need efficient and quality treatment to help them recover from symptoms including depression, anxiety, and PTSD. Upon immediate discovery of potential abuse, specifically sexual abuse, Teitelman (2006) recommended that direct service providers offer emotional support, reassure the victim that he or she is not to be blamed, and convey warmth and respect to have the older adult describe the alleged event. Teitelman discourages trying to analyze the circumstances and why it may have happened because it is has not proven to be helpful to the victim.

After the discovery of elder abuse, professionals often need to collaborate with other disciplines to get the required services, connections, and prosecutions the victim may be seeking. The use of multidisciplinary teams, such as with the forensic centers in Irvine and Los Angeles, California have proven to be effective in helping victims of elder abuse recover (Navarro, Wilber, Yonashiro, & Homeier, 2010; Wiglesworth, Mosqueda, Burnbright, Younglove, & Jeske, 2006). The Elder Justice Roadmap (U.S. Department of Justice, 2014) has placed these interdisciplinary teams as a high priority on a national level when responding to and treating elder abuse. Additionally, Horning, Wilkins, Dhanani, and Henriques (2013) have found an interdisciplinary team approach to be effective for older adults who have experienced financial abuse. Horning et al. also recommended that the team first address the client's safety and welfare before they focus on the emotional issues of the older adult. Further, Horning et al. recommended utilizing

caregiver education and family interventions to assist the entire family unit towards recovery.

A common clinical intervention for survivors of all types of elder abuse is to increase their social connections and access to community resources (Acierno et al., 2009). With increased social and community supports, elders will have greater support and reduce their risk of being completely dependent on one person for care. Survivor support groups have been shown to be effective but scarce; although there are elder abuse agencies in all states, many have few or no specialized programs for adults experiencing abuse in late life (Brandl, Hebert, Rozwadowski, & Spangler, 2003).

The few studies on survivor support groups have proven to be beneficial to the participants. Brandl et al. (2003) conducted research on 34 support group facilitators for elderly women who had been abused. Their research of the group facilitators revealed that the participants felt the group helped them cope by learning they were not alone, providing support, developing social contacts, learning new strategies for survival, enhancing their physical and mental health, and promoting peace and hope. Similarly, a study conducted in 1997 of 30 survivor support group leaders found that elders who participated in abuse support groups with others their age reported improved self-esteem, improved awareness of abuse, feelings of personal growth, increased ability to cope, and reduced feelings of isolation (Wolf, 2001). It is important to note that these studies may be biased since the group leaders were the respondents.

Another model of recovery is the use of an elder abuse shelter program or a long-term care program for survivors of abuse. Reingold (2006) described the first United States long-term care for elder abuse prevention and intervention at the Hebrew Home at

Riverdale in the state of New York. This model of care takes place in a long- or short-term shelter and utilizes a multidisciplinary team, integrated services, and peer support for the recovery of victims (Reingold, 2006). Upon entry to the shelter, the older adult has access to a registered nurse, social worker, and other health care providers who are trained to address the immediate needs of the victims within the first 24 to 48 hours (Reingold, 2006). A multidisciplinary team then develops a plan of care for each guest to either return the victim safely to his or her home with community support services, transfer him or her to special senior housing, or arrange for long-term admission to the Hebrew Home's residential health care facility (Reingold, 2006). Clients of Adult Protective Services in California rarely have access to these types of facilities. In September 2014, the statewide monthly report for California showed only 33 cases of elders receiving emergency shelter during the month.

There is minimal research on the specific types of therapeutic interventions that are useful for helping a victim of elder abuse overcome the emotional effects of this trauma. However, there is research on providing therapeutic interventions to older adults who are experiencing psychological symptoms such as anxiety and depression. For example, Wilson, Mottram, and Vassilas (2008) conducted a study of 153 older adults who were depressed and found that Cognitive Behavioral Therapy (CBT) was an effective intervention. Also, Hendriks, Oude Voshaar, Keijsers, Hoogduin, and Van Balkom (2008) conducted a study of 297 older adults who experienced depression and anxiety and found CBT to be effective. CBT is a form of psychotherapy where the clinician and patient work together to explore the relationships between the patient's thoughts, feelings, and behaviors (National Alliance on Mental Health, 2012).

In support of this research, a study conducted by Scogin, Morthland, Kaufman, Chaplin, and Kong (2011) showed that older, frail adults (n = 134) who were provided with in-home CBT had an increase in their quality of life, an increase in their self-rated health, and a decrease in their psychological symptoms upon follow-up. Furthermore, these outcomes were maintained 6 months after the treatment was complete (Scogin et al., 2011).

Multicultural Issues

In examining elder abuse, it is important to consider how culture and sexual orientation plays a role in the symptoms, detection, and response. This is especially important since people who belong to a non-white racial group have a higher risk of physical abuse, financial abuse, and neglect (Acierno et al., 2009). The four subcultures common to the Los Angeles County and Orange County will be examined here: Hispanic, African American, Asian, and the LGBT population.

Hispanics/Latinos

The Latino or Hispanic population is increasing in the United States and specifically in California. The Hispanic or Latino population consists of 17.1% of the population in the United States and consists of 38.4% of California's population. By 2050, the Hispanic population is expected to double in the United States (U.S. Census Bureau, 2008b). Due to factors such as immigration status, limited English proficiency, and fear of deportation, Latina elders are more likely than other women to experience isolation and therefore have higher rates of elder abuse (Parra-Cardona, Meyer, Schiamberg, & Post, 2007). Adding to this incidence of abuse is the cultural emphasis on the well-being of the family over the individual so they are less likely to report due to the

fear of getting their family in trouble (NCEA, 2014b). Cultural perceptions of elder abuse impact the reporting rates as well; financial abuse is often not recognized as abuse because it is normal for families to be codependent on each other (NCEA, 2014b). Once assistance has been implemented in an abusive situation, it has been shown that with supportive and nurturing environments, families who care for elders will be able to adapt to the needs of aging (Parra-Cardona, et al., 2007).

Asians

The Asian population encompasses various subgroups, including Cambodian, Chinese, Filipino, Japanese, Korean, and Vietnamese, (U.S. Census, 2014). This group is only 5.3% of the national average but is 14.1% of California's total population (U.S. Census, 2013). According to the NCEA (2013a), the traditional Asian culture emphasizes the family or group well-being over individual needs and may therefore affect the elder's willingness to seek help or to admit there is abuse occurring. By admitting to and reporting, abuse they would be seen as bringing shame to their family, something that is looked down upon by their community (NCEA, 2013a). Additionally, those within the Asian culture often have a narrow definition of abuse that predominately includes members of the family and they may not consider abuse of a stranger to be something they should report (NCEA, 2013a). Lastly, some elders view psychological mistreatment such as avoidance or disrespect as one of the worst forms of abuse or equal in severity to physical abuse (NCEA, 2013a).

African Americans

African Americans comprise 13.2% of the nation's population and 6.6% of California's total population (U.S. Census, 2013). African American elderly populations

are also at increased risk for elder abuse due to increased chronic health conditions, poverty level prevalence, and common living situations with other family members (Administration on Aging, 2011). According to the Administration on Aging, older African American adults are more than twice as likely to live in poverty compared to the general population. Additionally, they are more likely than the general population to have at least one major health condition such as diabetes, hypertension, and arthritis (Administration on Aging, 2011). Lastly, 40% of African American elderly women lived alone and 30% of elderly African American men lived alone (Administration on Aging, 2011), which is a significant risk factor if there is a lack of social relationships (Garre-Olmo et al., 2009).

Sexual Minorities

The LGBT populations are at high risk for abuse, neglect, and exploitation for numerous reasons. They are more likely to live in isolation, value self-sufficiency and refuse help, and may fear others knowing about their sexual orientation (NCEA, 2013b). It is estimated that there are 1.5 million LGBT adults 65 years or older living in the United States (LGBT Movement Advancement Project, SAGE, & Center for American Progress, 2010).

According to the above resource, LGBT elders are more likely to rely on their *family of choice* that includes friends and other informal caregivers since they often do not have children or a spouse. LGBT elders are generally poorer and less financially secure than most American elders (LGBT Movement Advancement Project & SAGE, 2010). It is more challenging for them to receive the health care they need due to health disparities being overlooked or ignored, limited government and social support for

“families of choice," an inhospitable health care environment, nursing homes failing to protect them, and visitation policies and decision-making laws which often exclude “families of choice” (LGBT Movement Advancement Project & SAGE, 2010).

It has been reported that as many as 8.3% of LGBT elders reported being neglected or abused due to their sexual orientation (LGBT Movement Advancement Project, SAGE, & Center for American Progress, 2010). Shankle, Maxwell, Katzman, and Landers (2003) explored the discrimination older LGBT persons encounter either implicitly or explicitly. This discrimination may impact their health and emotional well-being or lead to neglect and self-neglect (Shankle et al., 2003). These findings are further supported by a qualitative study conducted by Stein, Beckerman, and Sherman (2010) of 16 participants ages 60 to 84 who identified as being lesbian or gay. This study found common psychosocial challenges related to a fear of being rejected or neglected by health care providers, fear of not being accepted or rejected by other residents in a long-term care facility, and fear of having to deny their sexual orientation (Stein, Beckerman, & Sherman, 2010).

Conclusion

In conclusion, elder abuse is a widespread problem with serious, possibly deadly ramifications for the victim. As the older adult population grows in the United States, it is important for clinicians to be prepared to help those who have survived this traumatic experience. This includes a wide range of knowledge on elder abuse topics. In the therapeutic setting, it is important to understand all types of abuse and the common symptoms the victims often display to intervene quickly and effectively. By considering the cultural implications abuse may have on an individual and family, the clinician will

be able to be sensitive to their needs and understand their points of view when making important decisions. These decisions may be based on the legal ramifications of elder abuse and it is important for victims to know their rights and protections under the law. Once abuse is detected and the legal requirements have been fulfilled, it is important to then address the psychological effects victims may experience.

There is currently a lack of research exploring the therapeutic techniques that have been found most useful for survivors of elder abuse. Through interviews with clinicians, the types of interventions they have found to be effective are discussed and analyzed. This study takes into consideration the type of abuse the clinician has worked with, the culture of the victims, and the coping strategies utilized to address psychological trauma resulting from maltreatment.

CHAPTER 3

METHODS

Research Design

This study was exploratory using a qualitative interview approach. The researcher used an interview guide to interview professionals who worked with elder abuse survivors and their families to understand the therapeutic techniques they found to be most helpful. While there is much research on preventative efforts and the effects experienced by victims, there is little research that explores the specific interventions used to help victims cope with and recover from this traumatic experience.

Sampling Plan

This study consisted of interviews with 12 clinicians 18 years and older who have directly worked with people age 65 and older to help them overcome the psychological effects of elder abuse. The target sample size was 12 to 15 and completed using 12 clinicians who met these criteria. Participants were recruited through a snowball sampling method. The researcher began by interviewing those who volunteered and signed informed consent forms within her own personal and professional circles. Once the interview was completed, the researcher inquired about others whom the interviewee knew who have also worked with this population of older adults. Finally, those professionals would refer their contacts with the researcher's information to participate in the study.

Data Collection

Participants were contacted by the researcher and provided a consent form to participate in the research study. The consent form was collected immediately before the interview began. The interview was conducted at the time and place that best accommodated the interviewee, most of the time at their place of business.

The interview consisted of a 15- to 45-minute recorded interview. Recording was voluntary and did not include the identity of the participant. There were 11 recorded interviews and 1 declined to be recorded. If the participant declined to be recorded, the researcher took hand-written Hand written notes were taken instead of a recording. The participant who declined to be recorded was unable to meet in person so the interview took place via telephone. All other interviews took place in person. Once the recording was complete, the participant was not allowed to review, edit, or delete the recording. If the participant at any time became uncomfortable, the researcher emphasized that he or she would be welcome to stop at any time or continue at a different time.

Instrumentation

The interviews were structured following the interview guide with probing questions when needed. The guide was designed to gather details of the therapeutic interventions used by professionals when helping older adults cope with the effects of elder abuse. It was designed to be open-ended to facilitate discussion of the primary clinical symptoms these older adults present with in therapy and the specific techniques the professionals utilized to address psychological and emotional distress. This instrument took into consideration the various forms of abuse and how their techniques differed depending on the age, gender, or culture of the person. It allowed for discussion

of methods professionals used to empower older adults and their families to recover from and prevent abuse in the future. It also gave the clinicians the opportunity to add other information they felt was important to know about survivors of elder abuse.

The first part of the interview guide was to collect background information on the clinician and also to allow the interviewee to feel more comfortable talking about this sensitive subject. This included how the clients they worked with were referred to them or the organization with which they worked. It also collected the amount of time the clinician had been working with survivors of abuse.

The second part asked about the symptoms that were commonly seen in survivors of elder abuse and was designed to expand on the common characteristics and traits the survivors presented. These questions explored the clinical symptoms they saw as common in the survivors as well as the traits they had that helped in the personal recovery from abuse.

The third part of the interview focused on clinical techniques that were used to address the previously mentioned symptoms. Specifically, this section focused on how these techniques were adjusted, if at all, to the personal characteristics of the survivor and the type of abuse encountered. This portion of the interview was the most in-depth. It was designed to explore how strengths were used to help the survivors cope with and recover from the effects of abuse. Additionally, this part allowed the clinicians to share how they approached clients of different ages, cultural backgrounds, and genders. It examined how, if at all, did the clinical interventions fluctuate depending on the type of abuse suffered.

The fourth part of the interview expanded on the techniques by inquiring about involvement with family members and other support systems. This portion of the interview was designed to explore how clinicians utilized the entire family or support system of the survivor to facilitate understanding and long-term supports for the recovery of abuse. Clinicians were given the opportunity to discuss their involvement and therapeutic technics, if any, with the family members or support networks of the clients.

The fifth part of the interview was designed to be more open-ended. This part explored what type of preventative measures clinicians used to prevent future abuse of the survivor. It also had an open-ended question for the clinicians to voice any other information they felt was important for people to know about survivors of elder abuse.

The final portion of the interview collected general demographic information. This information included the participants' gender and ethnicity. It also included their educational level and years of experience working with older adults.

Data Analysis

After the interview, the researcher transcribed and analyzed the interview data and destroyed the recordings once this was complete. No identifying names were recorded and no names of employment agencies were revealed to protect the identity of the participants and to avoid any unintended repercussions. The researcher looked for patterns and common themes among the respondents to examine how professionals in the field have addressed elder abuse in a clinical setting.

CHAPTER 4

RESULTS

The purpose of this qualitative study was to explore, from the perspectives of clinicians, the therapeutic techniques they have found to be effective in helping older adults recover from the emotional and psychological effects of elder abuse.

Demographics

The total sample consisted of 12 clinicians who had worked with survivors of elder abuse in a therapeutic setting in Los Angeles County or Orange County, California. A demographic profile of the study sample can be found in Table 1. There were five demographic questions that asked participants their gender, ethnic group, how long they had been working with older adults, the highest level of education they completed, if they were licensed, and if so, what type of license they held.

As seen on Table 1, there were 10 (or 83.3%) female respondents and 2 (or 16.7%) male respondents. There were 3 (or 25.0%) participants who held a bachelor's degree and 8 (or 66.7%) who held a master's degree. Three (or 25.0%) identified themselves as a licensed clinical social worker (LCSW). The participants self-reported their ethnicities as follows: 5 (or 41.6%) identified as Caucasian, 3 (or 25.0%) identified as African American, 2 (or 16.7%) identified as Asian, and 2 (or 16.7%) identified as Hispanic or Latino. The years of experience of the participants varies widely. There were 4 (or 33.3%) participants who worked with older adults for 1 year or less, 3 (or

25.0%) participants who worked with older adults for 2 to 5 years, and the other 5 (or 41.7%) participants worked with older adults for 6 years or more.

TABLE 1. Participant Demographic Information ($N = 12$)

Characteristics	*f*	%
Gender		
Male	2	16.7
Female	10	83.3
Ethnicity		
African American	3	25.0
Asian/Filipino	2	16.7
Caucasian	5	41.6
Hispanic/Latino	2	16.7
Highest educational level		
Bachelor's	3	25.0
Master's	8	66.7
Ph.D.	1	8.3
Years clinicians worked with older adults		
1 year or less	4	33.3
2-5 years	3	25.0
6 or more years	5	41.7

Years of Clinician's Experience with Survivors of Abuse

Table 2 shows that the participants in this study have a wide range of experience working with older adults but mostly consist of clinicians with 10 years of experience or

less. There were 4 (or 33.3%) participants who had 1 year or less of experience working with elder abuse survivors, 3 (or 25.0%) participants had 2 to 5 years of experience, 2 (or 16.7%) participants had 6 to 10 years, and the remaining 3 (or 25.0%) participants had 11 years or more of experience.

TABLE 2. Years of Work with Survivors of Elder Abuse ($N = 12$)

Years	*f*	%
1 year or less	4	33.3
2 – 5 years	3	25.0
6 – 10 years	2	16.7
11 years or more	3	25.0

How Survivors Found Help

Table 3 illustrates that the survivors of elder abuse are referred to therapy through various means. The majority (9 or 75.0%) of clinicians reported referrals through mandated reporters. Half (6 or 50.0%) of the participants reported that the clients they worked with were referred though Adult Protective Services referrals and half (6 or 50.0%) were self-referrals to therapy. Five (or 41.7%) of the participants reported that they received referrals from community members who were concerned about an older adult. There were 3 (or 25.0%) of the clinicians who reported receiving referrals from other agencies.

TABLE 3. How Survivors Were Referred

Characteristics	*f*	%
Mandated reporters	9	75.0
Adult Protective Services	6	50.0
Self-referrals	6	50.0
People in the community/family/peers	5	41.7
Other agencies	3	25.0

Note: More than one response possible

Common Clinical Symptoms

Clinicians were asked to describe the common clinical symptoms the survivors of elder abuse presented with in the therapeutic setting. As shown in Table 4, the top two most common symptoms were depression and anxiety. A majority (11 or 91.7%) of the participants reported that depression was the most prevalent symptom. Two thirds (8 or

TABLE 4. Common Clinical Symptoms

Characteristics	*f*	%
Depression	11	91.7
Anxiety	8	66.7
Trauma/Post traumatic stress disorder (PTSD)	5	41.7
Fear	4	33.3
Cognitive impairment/Dementia	3	25.0
Hopelessness or loss	3	25.0

Note: More than one response possible.

66.7%) reported anxiety as a common symptom. The following quote explains the relationship between these two symptoms:

> There is a general sense of loss of control and this free floating anxiety about what is going to happen next because I [the elder] can't have any more control. That loss of control can lead to a sense of depression.

There were 5 (or 41.6%) clinicians who named trauma or PTSD as common, 4 (or 33.3%) clinicians who named fear, 3 (or 25.0%) clinicians who named a cognitive impairment, and 3 (or 25.0%) who observed hopelessness and loss. The following quote is representative of these symptoms:

> A lot of times we see depression. Trauma is number one especially if it has to do with verbal abuse or even financial abuse… The elder person knows about it but won't speak about it for fear they won't be able to return home…

Traits Common to Survivors that Facilitate Coping

Table 5 outlines the most common clinical traits displayed by survivors that are used to help them cope or recover from the effects of elder mistreatment. When asked about the common traits clinicians have seen in survivors that help them cope or recover from the abuse, there were many different answers but there were three in particular that were the most prevalent. Social supports were named by 50.0% (6) of clinicians.

TABLE 5. Common Traits Displayed by Survivors to Cope or Recover

Characteristics	*f*	%
Social supports	6	50.0
Community resources	6	50.0
Resilient or suffered loss before	4	33.3

Note: More than one response possible

Half (6 or 50.0%) of clinicians indicated that engagement in community resources was important to help older adult survivors. The following quote explains the importance of social connections and community resources:

> … there is this sense of, the survivors don't want to be shut in. They want to reintegrate and become socialized again. So getting them connected to some sort of day program or getting them reconnected with family…

The third area, mentioned by 4 (or 33.3%) of clinicians, was a resilient personality trait or the experience of successfully overcoming loss before. This loss may have been the loss of a spouse, family member, or previous abuse. By having overcome previous hardships, the victim was able to learn from those experiences and continue on. The following quote demonstrates this resiliency:

> I think it is past experiences from her life because she also felt other abuse so I think it is kind of the old school way of pulling yourself up by your boot straps and moving on.

Therapeutic Techniques to Address Symptoms of Abuse

TABLE 6. Therapeutic Techniques to Address the Symptoms of Abuse

Responses	*f*	%
Active listening	6	50.0
Cognitive Behavioral Therapy (CBT)	4	33.3
Life Review or Oral History	4	33.3
Strengths based approach	4	33.3

Note: More than one response possible

Even though there was a general consensus on the major symptoms survivors presented with in therapy, the therapy techniques utilized by the clinicians greatly varied. Table 6 shows the most common technique was active listening, which was reported by 6 (or 50.0%) of the participants. The importance of this technique is explained in the following quote:

> It may be that they need someone to listen to them and validate their feelings and let them know it is okay to feel that way. They can lead a different life if they want too; it's not too late to make changes.

Other interventions included Cognitive Behavioral Therapy (4 or 33.3%), life review or oral history (4 or 33.3%), and using strengths based approach (4 or 33.3%). Table 6 shows these results. These therapeutic interventions are explained in the following quotes:

> My role is to be there to listen to her and then also talk about the good things that have happened. I do a lot of lifetime reviews… It helps because they can look at the positive side of their lives versus what is happening now. It helps them see I [the elder] am more than what was happening.

> I really think Cognitive Behavioral Therapy is helpful because I think what usually lingers is mood disorder, anxiety, depression, or mild trauma. In addition to that, being empathetic and being a good listener and letting people really talk about what they have been through. A lot of time they have a lot of negative messages that have been told to them by the person who was the perpetrator and undoing these messages takes work and not blaming themselves takes work.

Personalizing Techniques for the Survivor

Table 7 displays how the therapists varied their techniques depending on the age, gender, or culture of the victim. One third (4 or 33.3%) would take into consideration the limited physical or mental abilities of their client. This adjustment was described in the following quote:

TABLE 7. How the Techniques Differ by the Survivor's Age, Gender, or Culture

Characteristics	*f*	%
Physical or mental ability of the individual	4	33.3
Culture	4	33.3
Age	3	25.0
Gender	3	25.0

Note: More than one response possible

> I had to adjust with her because she is hard of hearing and she has trouble seeing so I can't do things like give her a lot of handouts because she really can't see very well at all… I think doing reminiscence with someone who still has their memory intact is really effective for someone who is older who can't do things like writing or reading.

The other common characteristic that 4 (or 33.3%) of the clinicians take into consideration is the culture of the victim. This adjustments was described in the following quote:

> It varies. Some cultures are more family oriented and want everyone involved so there is a lot of family work. Other cultures are more focused on self and worried about "saving face" and retaining independence. You proceed differently with these by doing a lot of individual work. You really need to understand and have a competence of their culture.

The other characteristics were slightly less common. There were 3 (or 25.0%) of clinicians that stated age would influence their techniques and 3 (or 25.0%) of clinicians that stated gender would influence their techniques. With gender, it was mentioned that there are generally more women survivors of abuse and that male survivors are less talkative and less prevalent. The following quote discusses differences in gender:

> Gender, in general, males seek less help with abuse. It goes against their grain of being. Males are not as vulnerable and not as open to help compared to females. Males do not open to feelings as easily as females. Females need to talk, think out loud. Males have already processed it by the time they speak. When working

with males, for example in grief counseling, we will not sit in my office; instead, we will go for a walk. They are better in dealing with emotions when doing an activity.

A lot of men they don't say anything. It's harder because I think see it as them being weak. A lot of the nurses are female so if the nurses are the perpetrators, they are being hit by a female. Which I think they internalize as being weak. They are less open to talk about it. We get more women than men…"

Personalizing Techniques for the Type of Abuse

TABLE 8. How Techniques Differ by Type of Abuse

Characteristics	*f*	%
Everyone is unique	4	33.3
Yes, techniques need to differ	3	25.0
Address emotions	3	25.0
Provide education	3	25.0

Note: More than one response possible

Table 8 shows the data on how clinicians change or do not change their interventions depending on the form of abuse their client has suffered. Much like how the techniques differed depending on the personal characteristics of the survivor, the clinicians had different responses for how their techniques would change based on the different types of abuse. The most frequent response was from 4 (or 33.3%) of clinicians that everyone is unique. As the following quotes explain, the interventions are based on the individual, not the type of abuse they endured:

It goes back to really knowing, finding out about that individual and what is going to help them because, like I said, what could work for one person might not work

> for another person. All of these things are abuse… and how it affects everyone is going to be different and how you work with everyone is going to be different.
>
> I don't look at the type of abuse as any different. Unless someone is seriously injured at that time, I treat them all the same because it seems like all of the symptoms of anxiety and depression are present regardless of the type of abuse.

There were 25.0% (or 3) of the clinicians who felt that the type of abuse does matter and just as many who felt that the type of abuse does not matter in their interventions. There were 25.0% (or 3) of the respondents who would address the emotions of the client and 25.0% (or 3) also stated that they would provide education**.** Some of the interventions differed as shown in the quotes below:

> The physical abuse is easy, you have to be more directive, more pragmatic. You address those issues, and it is more easily aligning, you can align with your client more easily, beating is bad… Your daughter is taking away your money or your son…now you are dealing with more psychosocial in that sense. There is a psychosocial component to abuse but keeping them safe is easy; you don't want to be near the person who hit you.

In contrast, this next quote from a different clinician shows that he or she would be more directive with financial abuse and more emotional when discussing physical abuse:

> When it comes to financial abuse, you definitely have to be more factual and it doesn't really play on emotions as much, so I've noticed… The physical and the self-neglect and the psychological abuse is definitely more based on emotion, as expected. The motivational interviewing, strengths based, that really helps out more with helping the adult to identify their needs and be able to improve their situation and get help…

Types of Involvement with Family or Support Networks

The clinicians in this study reported having little involvement with the family members, as shown in Table 9. They were either not allowed to speak with the family due to agency regulations or the family was not interested in being involved or getting help. There were 4 (or 33.3%) of respondents who reported that they do not work with

the family at all and 3 (or 25.0%) who reported that the family is usually not interested in getting help.

There were different reasons given as to why the family is not active in the elder's life. The following quotes describe why the family may not be involved:

> The clients that we see, they have family but there is conflict within the family where they are alienated and where they are no longer involved in family events, like holidays, for example. It is really just working with the clients.

TABLE 9. Therapeutic Involvement with Family or Support Networks

Characteristics	*f*	%
Refer to other agencies	9	75.0
Do not work with family	4	33.3
Family not interested in help	3	25.0
Provide education	3	25.0
Refer to support groups	3	25.0
Reduce caregiver stress and burnout	3	25.0

Note: More than one response possible

> You really have to feel the family out to see if they are hostile. If it is a hostile environment…it will be questions in general about the care and if they need any help in the home and we give them resources for in home supportive services. If the caregiver needs help and is overwhelmed, we give them the caregiver support group information but that is about as far as we go with the caregiver unless they are really receptive.

Of the respondents, 9 (or 75.0%) reported that they refer the family members to other agencies for assistance. Other interventions included education (3 or 25.0%), referrals to support groups (3 or 25.0%), and reduce the stress and burnout rate of the

caregivers (3 or 25.0%). Examples of interactions with the family or support networks are explained by the following quotes:

> We definitely educate. It is very psychoeducational in terms of letting the client's family members know there are services out there. For instance, we do a lot of referrals… We like to inform our clients' family members about respite care and the importance of taking care of themselves because caregiving is a very, very hard thing.

> If it is other outside family who are not aware of the abuse, they are allowed to visit. We don't so much help the family as much as I would like to because our whole goal is the resident. We have flyers and information where they can go out to community resources and connecting with other resources…

Therapeutic Techniques for Support Networks

Education was the most provided intervention (7 or 58.3%) for family members and support networks (see Table 10). A smaller percentage of clinicians provide active listening (5 or 41.7%) and (5 or 41.7%) conduct a family meeting. Also of importance, 4 (or 33.3%) clinicians reported that they will help the family members to process their feelings related to the abuse and 4 (or 33.3%) reported that they provide referrals for added support.

TABLE 10. Therapeutic Techniques for Family Members

Characteristics	*f*	%
Education	7	58.3
Active listening	5	41.7
Family meeting	5	41.7
Process feelings	4	33.3
Provide referrals	4	33.3

Note: More than one response possible

The following quotes identify family therapy techniques:

> What I would do would be more psychoeducation with them as far as what their family member is going through and the cycle of violence, the types of domestic violence, elder abuse, things like that…

> Just supportive counseling, listening to their stories, a lot of them just really need to vent. Let them vent and express their concerns and see if they are willing or receptive to whatever we have to provide them in the community.

In working with the family members, I am really trying to make sure the client is hearing what they are saying so it is a lot of listening, reflecting, and processing feelings… Also helping the family members understand the client has self-determination and they have to be patient.

Preventing Abuse

TABLE 11. Preventing Future Abuse

Characteristics	*f*	%
Education (community or individual)	10	83.3
Community education	5	41.7
Individual education to older adults	5	41.7
Socialization	3	25.0

Note: More than one response possible

While individual techniques of the clinicians may differ, Table 11 shows there is more of a consensus on how to prevent future abuse with survivors of elder abuse. There were 10 (or 83.3%) of clinicians who recommended education, 5 (or 41.7%) thought the community at large needs to become more aware of elder abuse, and 5 (or 41.7%) thought the focus should be on educating older adult clients. The following quotes illustrate the prevention themes:

> Really it is important to get the word out there and educate people on elder abuse, what it looks like and what are the red flags. I think education is key. It is the biggest thing… Individually working with the clients in therapy to help them with their problem solving skills and being able to notice those red flags so they don't get into another abusive relationship.
>
> A lot of them don't realize they are being abused and that it is either part of their culture or part of the aging process. Because I [the elder], myself, am not able to do things anymore, this is why my children are treating me this way or why the caretaker is this way too. I think education is a big one…

The final method of preventing abuse was agreed upon by 3 (or 25.0%) of respondents, which is to have the survivor become more social and develop more support networks so they remain engaged and do not fall back into the depression that triggered the abuse in the first place. The following quotes represent this:

> Ensuring significant social supports, healthy social supports I should say. Making sure that not only the victim has it but that the perpetrator does as well.
>
> If they have an unmet need for contact with people, maybe that is what made them vulnerable to someone taking advantage of them. Then finding ways to meet that need in a safe way for them. Just helping them know what a healthy relationship is. Hopefully they haven't given up on forming those relationships.

Other Information about Survivors

This question was open-ended and left the subject open to the clinician to discuss any other information they felt was important about those who survived elder abuse. There were 5 (or 41.7%) of respondents who emphasized prevention and the need for more prevention efforts in the community as explained in the following quote:

> There is some shame associated with being a victim of elder abuse, even though there shouldn't be, there is some shame and stigma related to it. We need more centers for the prevention of elder abuse, for victims, and more groups in the community for survivors of elder abuse. I think we need more information, clinically, on how to help older adults.

TABLE 12. Other Information About Abuse Survivors

Characteristics	*f*	%
Prevention is important	5	41.7
They are resilient/survivors	4	33.3
Need community connections	2	16.7
Need support systems	2	16.7

Note: More than one response possible

Another common theme was that 4 (or 33.3%) of respondents emphasized that the older adults they work with are survivors and have a lot of resiliency developed over years of experience. The following quote details this aspect:

> They always can. Our seniors, given what they have been through in the last 60 to 80 years, they have been through a lot and their resiliency is amazing! Sometimes they will even surprise themselves.

The two final themes that emerged were a need for increased community connections to serve this population and the need for older adults to have reliable support systems. The following quote explains the need for community connections and for ongoing social supports:

> There are some people who are not in abusive situations anymore but they are still dealing with the effects of it. They are still dealing with the trauma. They don't understand how this happened. They are feeling ashamed, embarrassed, and guilty. So even helping them stay connected in their communities, especially to make sure they do not go off by themselves and just live alone. Making sure they have a support system.

CHAPTER 5

DISCUSSION

The purpose of this study was to explore, from the perspectives of clinicians, the therapeutic techniques they have found to be effective in helping older adults recover from the effects of elder abuse. This study revealed the common clinical symptoms survivors of elder abuse present with in a clinical setting. This study also revealed the various therapeutic techniques clinicians use to address these symptoms while also taking into consideration the gender, culture, and age of the victim. In addition to these personal characteristics, the ways these clinical techniques are altered depending on the type of abuse suffered by the older adult was considered.

Summary of Findings

The results of this study indicate that clinicians generally see similar symptoms in survivors of elder abuse, including depression, anxiety, trauma, and fear. These symptoms reflect the research from the CDC (2010) stating that victims of elder abuse are at increased risk for anxiety, PTSD, and learned helplessness. Additionally, these symptoms mirror early research showing that victims of abuse display increased symptoms of depression compared to individuals who did not report a past history of abuse (Pillemer & Prescot, 1988). A review of the literature by Wolf (2000) showed that most victims of elder abuse displayed feelings including fear, anxiety, guilt, and PTSD.

Methods for addressing those symptoms are varied and include a wide range of techniques and interventions, including CBT, active listening, life reviews, making referrals, and using a strengths-based approach. Using various therapeutic methods corresponds with the research by Papadopoulos and La Fontaine (2000), which found that each individual situation is unique in terms of the personal characteristics of the person, coping abilities, type of abuse endured, duration of abuse, and the meaning the person attaches to the experiences. The techniques revealed in this study mirror research on the effectiveness of providing CBT to people who suffer from symptoms of anxiety and depression (Scogin et al., 2011). There is also research suggesting that it is beneficial to make referrals to get the victim of abuse to socialize more and become reintegrated into his or her community (Acierno et al., 2009). Furthermore, the need for more support groups for survivors of elder abuse is consistent with Brandl et al.'s (2003) work, which found a lack of these types of groups.

Clinicians indicated that they modified their interventions based on the survivor's gender, culture, or age. Some clinicians would use different approaches when working males versus females. Additionally, the clinicians interviewed in this study used various types of interventions which depended on the type of mistreatment suffered by the survivor. For example, some clinicians used more education in cases of financial abuse as opposed to emotional or physical abuse they would do much more active listening and provide more empathy. Studies have shown that it is important to examine the different types of abuse individually, since they have different risk factors (Garre-Olmo et al., 2009; Jackson & Hafemeister, 2011). However, the psychological effects on victims

after abuse has occurred are unique. This may help explain why the clinicians in this study utilize various techniques.

There was minimal family involvement reported by the clinicians in this study. Some were prevented from working with the family due to agency policies, while others expressed that most family members were unmotivated to see them. When clinicians did work with the family, the main interventions were education, active listening, and holding family meetings. The clinicians provided education at the family meetings around what abuse is, how it manifests, and the consequences.

Perhaps this lack of information surrounding elder abuse is why this study revealed a high demand from clinicians for more prevention efforts and education around elder abuse. There are limited resources for elderly people who are in need of abuse-specific resources such as support groups or housing for elders fleeing abuse. While there are agencies that specialize in elder abuse in every state, many have few or no specialized support services for elderly victims (Brandl et al., 2003). This is seen in this study with the clinicians expressing the need for more resources to assist the victims who are on the road to recovery.

Limitations of the Study

There were several limitations of this study. First, for a qualitative design, this study included a low number of participants. The researcher was limited to the minimum number of participants due to this group of clinicians being difficult to locate with few agencies in the community providing services to this population. Second, the face-to-face interview design posed other limitations, even though the researcher was patient and allowed the participants to think about the questions, they may have not covered

everything because of limited time due to other duties. Given that their first time hearing the questions was at the interview, they may not have had enough time to reflect on the question and thus gave the first response that came to mind. Third, geographic limitations were present as well since all interviewed clinicians worked in Los Angeles County or Orange County, California. The findings may not be applicable to other regions and cultures outside of these counties and state. Fourth, although the researcher carefully reviewed each question and response, the findings may be biased based on the personal views of the researcher.

The final limitation is that the study did not examine each type of abuse individually. All forms of abuse (financial, emotional, physical, sexual, and neglect) were grouped together. The type of interventions may vary depending on each specific abuse. For example, the interventions used for fiduciary abuse may be different than those used for sexual abuse.

Implications for Social Work Practice

Despite these limitations, these results may be beneficial for geriatric social work practice. The results of this study indicated that social workers need to be educated on the signs, symptoms, and effects of mistreatment among elders. More training on how to provide clinical treatment to older adult survivors of elder abuse is also clearly needed. Additionally, social workers need to be prepared to work across cultural groups, since elder abuse can be perceived differently depending on one's cultural view. The need for additional resources for this population speaks to the demand for more community and political interventions to prevent elder abuse. Social workers have an ethical responsibly

to educate policy makers and to advocate for services for the growing older adult population.

Implications for Further Research

This study revealed that there is more research that needs to be done on the types of interventions that have been useful in helping older adults recover from the effects of elder abuse. Practitioners are generally in agreement about the common psychological symptoms of the survivors and there were various interventions utilized to address those symptoms. Further research is needed to explore the most effective interventions for each type of abuse experienced by older adult survivors.

In future studies, it would be helpful to know the setting in which the clinicians working in and what type of abuse they see as most common in that setting. Since family members are the perpetrators in three fourths of all elder abuse cases (Acierno et al., 2009), it would be helpful to understand the benefits of working with the family members or support networks.

Perpetrators of abuse are also another area for future study and additional resources. Areas for exploration with perpetrators include what causes them to abuse and what types of interventions are most effective to change the abusive behavior? This information will help clinicians develop specific goals when working with this population.

Summary

In conclusion, this study explored the symptoms commonly seen in survivors of elder abuse and what type of interventions clinicians have used to address those symptoms and to facilitate the recovery from the traumatic experience. This study also

discussed how these techniques may or may not differ depending on the personal characteristics of the elder and the type of abuse encountered. In addition, clinicians discussed what kind of interaction they had with the family members and what types of clinical interventions were used with the family. Finally, clinicians provided insight as to how they prevent abuse with their clients and recommendations for prevention and awareness within the larger community.

APPENDICES

APPENDIX A

INFORMED CONSENT LETTER

Therapeutic Needs of Older Adult Survivors of Elder Abuse:
Perspectives from Clinicians
INFORMED CONSENT FORM
CONSENT TO PARTICIPATE IN RESEARCH

You are asked to participate in a research study conducted by Catherine E. Adkins, MSW student from the School of Social Work at California State University, Long Beach. The study will contribute towards my thesis. You were selected as a possible participant in this study because you are 18 years of age or older and have experience working with elder abuse survivors in a therapeutic setting.

PURPOSE OF THE STUDY

From the perspective of professionals who work with older adults, the purpose of this study is to examine therapeutic techniques professionals have found to be effective in helping older adults cope with the emotional and psychological effects of elder abuse.

PROCEDURES

If you agree to participate in the study, simply sign this consent form. After you sign and date the consent form I will conduct a 45-60 minute telephone or a face-to-face interview. You will be asked to answer questions regarding the experiences you have of providing clinical interventions to survivors of elder abuse. If you choose not to be audio taped, I will take handwritten notes.
If the interview is held in person, I will arrange to meet with you at your place of employment, a library or a coffee shop.

POTENTIAL RISKS AND DISCOMFORTS

The potential risks of this research include emotional disturbance due to the sensitive nature of this topic and potential discomfort answering questions about your successes or failures in therapy with older adults who faced elder abuse. Additionally, a potential risk will be a breach of confidentiality with the written and audio record of the interview. Every effort will be made to ensure there is no breach of confidentiality. The files will be transported in a locked cabinet in the locked truck of the researcher's vehicle. Files will be available to the thesis advisor and the researcher. Files will be kept confidential in a locked cabinet in the researcher's home. Only the researcher will have the key to the file.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Although you are not expected to benefit directly by your participation, it is hoped that the results will assist social workers to gain a better understanding of what interventions are effective pertaining to interventions beneficial in aiding the recovery of those affected by elder abuse.

PAYMENT FOR PARTICIPATION

There will be no monetary or compensation for participating in this study.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. I am required to report any information that may indicate harm to self or others.
Consent forms will be kept separate from data at all times. Audio tapes will be destroyed immediately after they are transcribed and analyzed. The researcher will keep consent forms, transcripts, and handwritten notes in a locked cabinet for three years from the date the study is completed and then they will be destroyed.
Participants will not be allowed to review edit or erase the tape due to time constraints.
The researcher and the thesis advisor will be the only individuals who will have access to the data collection materials.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. Participation or non-participation will not affect your benefits or any other personal consideration or right you usually expect. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise in which in the opinion of the researcher warrant doing so.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact me at (562) 387-6048 or my thesis advisor, Dr. Molly Ranney, at (562) 985-4684.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact the Office of University Research, CSU Long Beach, 1250 Bellflower Blvd., Long Beach, CA 90840; Telephone: (562) 985-5314 or email to orsp@csulb.edu.

SIGNATURE OF RESEARCH SUBJECT

I understand the procedures and conditions of my participation described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Printed Name of Subject

_____ _____
Signature of Subject Date

Consent for Audio Taping:

_____
Signature of Subject

APPENDIX B

INTERVIEW GUIDE

Therapeutic Needs of Older Adult Survivors of Elder Abuse:

Perspectives from Clinicians

Interview Guide

I would like to begin the interview by collecting some background information.

1. How were the people you helped referred to you/this organization?

2. How long have you been working with survivors of elder abuse?

Next, I would like to ask you about symptoms commonly seen in survivors of elder abuse.

3. What clinical symptoms do you see as common in survivors of elder abuse?
   A. Probes:
      1) Depression?
      2) Anxiety?
      3) Trauma?

4. What are the common traits that survivors have to help them cope or recover?
   A. Probes:
      1) Resilience?
      2) Spirituality?
      3) Family or social supports?

Next, I would like to ask you about clinical techniques you have used to address these symptoms.

5. What therapeutic techniques have you found to be helpful in the emotional or psychological recovery from elder abuse?
   A. Probes:
      1.) Cognitive Behavioral Therapy?
      2.) Grief Therapy?
      3.) General Support?

6. How do these techniques differ depending on the victim's age, gender, culture of the victim?
   Probes:
      1) Art therapy?
      2) Cognitive Behavioral Therapy?
      3) Increased collaboration with support networks?

7. How do these techniques differ depending on the type of abuse suffered?
Probes:
    1) Focus on education for financial abuse?
    2) Increased empathy and validation for sexual abuse?

Next, I would like to ask you about other support systems that are utilized to assist in the recovery.

8. What type of therapeutic involvement do you do with the family members or support networks of your client?
Probes:
    1) Individual counseling?
    2) Refer to support group?

9. Are there therapeutic techniques you have found helpful when speaking with the family members or support networks?
Probes:
    1) Cognitive Behavioral Therapy?
    2) Grief Therapy?
    3) General support?

Next, I would like to ask you opinion on what can be done to prevent elder abuse.

10. What kind of preventative measures do you use to prevent future abuse with the client?

11. Is there any other information you feel is important that we know about those who have survived elder abuse?

Last, I would like to ask you some demographic information.

12. Gender:

13. What ethnic group do you identify with?

14. What the highest level of education you have completed?
Probe:
If licensed, what type of license do you hold?

15. How many years have you been working with older adults?

REFERENCES

REFERENCES

Acierno, R., Hernandez-Tejada, M., Muzzy, W., & Steve, K. (2009). *The national elder mistreatment study*. Washington, DC: National Institute of Justice.

Administration on Aging. (2011). *A statistical profile of Black older Americans aged 65 +*. Retrieved from http://aoa.gov/AoARoot/Aging_Statistics/minority_aging/Facts-on-Black-Elderly-plain_format.aspx

Administration on Aging. (n.d) *The U.S. older populations reaches a new zenith as baby boomers turn 65*. Retrieved from http://aoa.gov/AoAroot/Press_Room/Social_Media/Widget/Statistical_Profile/2010/3.aspx

Alzheimer's Association. (2014). *Alzheimer's facts and figures*. Retrieved from http://www.alz.org/alzheimers_disease_facts_and_figures.asp#quickFacts

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Arlington, VA: Author.

American Psychological Association. (2014a). *Elder abuse*. Retrieved from http://www.apa.org/pi/prevent-violence/resources/elder-abuse.aspx

American Psychological Association. (2014b). *Elder abuse and neglect: In search of solutions*. Retrieved from http://www.apa.org/pi/aging/resources/guides/elder-abuse.aspx

Anetzberger, G. J. (2012). An update on the nature and scope of elder abuse. *Journal of the American Society on Aging 36*(3), 12-20.

Baker, A. A. (1981). Granny battering. *International Journal of Family Psychiatry*, *2*(3-4), 369-378.

Brandl, B., Hebert, M., Rozwadowski, J., & Spangler, D. (2003). Feeling safe, feeling strong: Support groups for older abused women. *Violence Against Women, 9*(12), 1490-1503. doi:10.1177/1077801203259288

Burston, G. R. (1975). Granny battering. *The British Medical Journal*, *3(*5983), 592.

California Department of Social Services. (2007). *Services*. Retrieved from http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm

California Department of Social Services. (2014). *Adult protective services and county services block grant monthly statistical report (SOC 242) June 2014 (Version 1)*. Retrieved from http://www.cdss.ca.gov/research/PG345.htm

California Welfare and Institutions Code, Sections 15630-15632. (1986). Retrieved from http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15630-15632

Centers for Disease Control and Prevention. (2010). *Elder maltreatment: Consequences*. Retrieved from http://www.cdc.gov/violenceprevention/elderabuse/consequences.html

Centers for Disease Control and Prevention. (2012). *Health related quality of life*. Retrieved from: http://www.cdc.gov/hrqol/

Centers for Disease Control and Prevention. (2013). *Percentage of adults aged 60 years or older with diagnosed diabetes who needed assistance with activities of daily living (ADL), by age, United States, 1997–2011*. Retrieved from http://www.cdc.gov/diabetes/statistics/activities/fadlbyage.htm

Centers for Disease Control and Prevention. (2014). *Elder abuse definitions*. Retrieved from http://www.cdc.gov/violenceprevention/elderabuse/definitions.html

Comijs, H., Penninx, B., Knipscheer, K., & Van Tilburg, W. (1999). Psychological distress in victims of elder mistreatment: The effects of social support and coping. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *54*(4), 240-P245.

Cook, J. M., Dinnen, S., & O'Donnell, C. (2011). Older women survivors of physical and sexual violence: A systematic review of the quantitative literature. *Journal of Women's Health*, *20*(7), 1075-1081. doi: 10.1089/jwh.2010. 2279.

Crimes Against Elders, Dependent Adults, and Persons with Disabilities, California Penal Code § 368.5 (2010). Retrieved from http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=00001-01000&file=368-368.5

Dong, X.Q., Simon, M., Mendes de Leon, C., Fulmer, T., Beck, T., Hebert, L, . . . Evans, D. (2009). Elder self-neglect and abuse and mortality risk in a community-dwelling population. *JAMA, 302*(5), 517-526.

Donovan, K., & Regehr, C. (2010). Elder abuse: Clinical, ethical, and legal considerations in social work practice. *Clinical Social Work Journal, 38*, 174-182. doi: 10.1007/s10615-010-0269-2

Frolik, L. A., & Whitton, L. S. (2010). *Everyday law for seniors*. Boulder, CO: Paradigm

Gainey, R. R., Payne, B. K., & Kropf, N. (2010). Neighborhood disadvantage and refusal of formal services among cases reported to Adult Protection Services. *Journal of Evidence Based Social Work, 7*, 348-360. doi: 10.1080/15433710903256906

Garre-Olmo, J., Planas-Pujol, X., Lopez-Pousa, S., Juvinya, D., Vila, A., Vilalta-Franch, J., & Frailty and Dependence in Girona Study Group. (2009). Prevalence and risk factors of suspected elder abuse subtypes in people aged 75 and older. *The American Geriatrics Society, 57*, 815-822. doi: 10.1111/j.1532-5415.2009. 02221.x

Hendriks, G., Oude Voshaar, R., Keijsers, G., Hoogduin, C., & Van Balkom, A. (2008). Cognitive-behavioral therapy for late-life anxiety disorders: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 117*(6), 403-411.

Horning, S.M., Wilkins, S.S., Dhanani, S., & Henriques, D. (2013). A case of elder abuse and undue influence: Assessment and treatment from a geriatric interdisciplinary team. *Clinical Case Studies, 12*(5), 373-387. doi: 10.1177/1534650113496143

Jackson, S., & Hafemeister, T. (2011). Risk factors associated with elder abuse: The importance of differentiating by type of elder maltreatment. *Violence and Victims*, *26*(6), 738-757.

Laumann, E., Leitsch, S., & Waite, L. (2008). Elder mistreatment in the United States: Prevalence estimates from a nationally representative study. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *63*(4), S248.

LGBT Movement Advancement Project & SAGE. (2010). *Improving the lives of LGBT older adults*. Retrieved from http://www.lgbtmap.org/file/ improving-the-lives-of-lgbt-older-adults.pdf

LGBT Movement Advancement Project, SAGE, & Center for American Progress. (2010). *LGBT older adults: Facts at a glance*. Retrieved from http://www. americanprogress.org/ issues/lgbt/report/2010/09/28/8411/protecting-our-lgbt-elders/

Muehlbauer M., & Crane, P. A. (2006). Elder abuse and neglect. *Journal of Psychosocial Nursing, 44*(11), 43-48.

National Adult Protective Services Association. (2014a). *Get help*. Retrieved from http:// www.napsa-now.org/get-help/how-aps-helps/

National Adult Protective Services Association. (2014b). *History: About Adult Protective Services from 1960 to 2000*. Retrieved from http://www.napsa-now.org/about-napsa/ history/history-of-adult-protective-services/

National Alliance on Mental Health. (2012). *Treatment and services*. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/Cognitive_Behavioral_Therapy1.htm

National Center on Elder Abuse. (1998). *The National elder abuse incidence study*. Retrieved from http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf

National Center on Elder Abuse. (n.d.) *Statistics/data*. Retrieved from http://www.ncea.aoa. gov/Library/Data/

National Center on Elder Abuse. (2013a). *Mistreatment of Asian Pacific Islander (API) elders*. Retrieved from http://www.ncea.aoa.gov/Library/Review/Brief/index.aspx

National Center on Elder Abuse. (2013b). *Mistreatment of lesbian, gay, bisexual, and transgendered (LGBT) elders*. Retrieved from http://www.ncea.aoa.gov/Library/Review/Brief/index.aspx

National Center on Elder Abuse. (2014a). *Frequently asked questions*. Retrieved from http://www.ncea.aoa.gov/faq/index.aspx

National Center on Elder Abuse. (2014b). *Mistreatment of Latino elders*. Retrieved from http://www.ncea.aoa.gov/Library/Review/Brief/index.aspx?utm_source=streamsend&utm_medium=email&utm_content=22031549&utm_campaign=Elder%20Abuse%20News%20Bytes%20-%20Summer%20Issue

National Research Council. (2003). *Elder mistreatment: Abuse, neglect, and exploitation in an aging America*. Washington, DC: The National Academies Press.

Navarro, A.E., Wilber, K.H., Yonashiro, J., & Homeier, D.C. (2010). Do we really need another meeting? Lessons from the Los Angeles County elder abuse forensic center. *The Gerontologist 50*(5), 702-711. doi: 10.1093/geront/gnq08

Papadopoulos, A., & La Fontaine, J. (2000). *Elder abuse: Therapeutic perspectives in practice*. Buckinghamshire, United Kingdom: Speechmark Publishing Limited

Parra-Cardona, J.R., Meyer, E., Schiamberg, L., & Post, E. (2007). Elder abuse and neglect in Latino families: An ecological and culturally relevant theoretical framework for clinical practice. *Family Process 46*(4), 451-470.

Pillemer, K., & Prescott, D. (1988). Psychological effects of elder abuse: A research note. *Journal of Elder Abuse and Neglect 1*(1), 65-73.

Reingold, D.A. (2006). An elder abuse shelter program: Build it and they will come, a long term based program to address elder abuse in the community. *Journal of Gerontological Social Work 46*(3-4), 123-135. doi: 10.1300/J083v46n03_07

Schiamberg, L., Oehmke, J., Zhang, Z., Barboza, G., Griffore, R., Von Heydrich, L., … Mastin, T. (2012). Physical abuse of older adults in nursing homes: A random sample survey of adults with an elderly family member in a nursing home. *Journal of Elder Abuse & Neglect*, *24*(1), 65-83.

Scogin, F., Morthland, M., Kaufman, A., Chaplin, W., & Kong, G. (2011). Maintenance of quality of life improvements in diverse rural older adults. *Psychology and Aging*, *26*(2), 475-479. doi:10.1037/a0022130

Shankle, M. D., Maxwell, C. A., Katzman, E. S., & Landers, S. (2003). An invisible population: Older lesbian, gay, bisexual, and transgender individuals. *Clinical Research & Regulatory Affairs*, *20*(2), 159-182.

Stein, G.L., Beckerman, N.L., & Sherman, P.A. (2010). Lesbian and gay elders and long-term care: Identifying the unique perspectives and challenges. *Journal of Gerontological Social Work, 53*(5), 421-435. doi: 10.1080/01634372.2010.496478

Teaster, P., Ramsey-Klawsnik, H., Mendiondo, M., Abner, E., Cecil, K., & Tooms, M. (2007). From behind the shadows: A profile of the sexual abuse of older men residing in nursing homes. *Journal of Elder Abuse & Neglect*, *19*(1-2), 29-45.

Teaster, P., & Roberto, K. (2003). Sexual abuse of older women living in nursing homes. *Journal of Gerontological Social Work*, *40*(4), 105.

Teitelman, J. (2006). Sexual abuse of older adults: Appropriate responses for health and human services providers. *Journal of Health and Human Services Administration 29*(2), 209-227.

U.S. Census Bureau. (2008a). *Projections of the population by selected age groups and sex for the United States: 2010 to 2050*. Retrieved from https://www.census.gov/population/projections/data/national/2008/summarytables.html

U.S. Census Bureau. (2008b). *Projections of the population by sex, race, and Hispanic origin for the United States: 2010 to 2050*. Retrieved from https://www.census.gov/population/projections/data/national/2008/summarytables.html

U.S. Census Bureau. (2010). *Projections of the population by selected age groups and sex for the United States: 2010 to 2050*. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

U.S. Census Bureau. (2013). *State & county quick facts: California*. Retrieved from http://quickfacts.census.gov/qfd/states/06000.html

U.S. Census Bureau. (2014). *State & county quick facts*. Retrieved from http://quickfacts.census.gov/qfd/meta/long_RHI425213.htm

U.S. Department of Justice. (2014). *The elder justice roadmap; A stakeholder initiate to respond to an emerging health, justice, financial and social crisis*. Retrieved from http://ncea.acl.gov/Library/Gov_Report/docs/EJRP_Roadmap.pdf

Werner, C.A. (2011). *The older population: 2010*. Washington, DC: U.S. Department of Commerce: Economics and Statistics Administration. Retrieved from the U.S. Department of Commerce, Economics and Statistics Administration website: http://www. census.gov/prod/cen2010/briefs/c2010br-09.pdf

Wiglesworth, A., Mosqueda, L., Burnbright, K., Younglove, T., & Jeske, D. (2006). Findings from and elder abuse forensic center. *The Gerontologist, 46*(2), 277-283.

Wiglesworth, A., Mosqueda, L., Mulnard, R., Liao, S., Gibbs, L., & Fitzgerald, W. (2010). Screening for abuse and neglect of people with dementia. *Journal of the American Geriatrics Society*, *58*(3), 493-500.

Wilson, K., Mottram, P., & Vassilas, C. (2008). Psychotherapeutic treatments for older depressed people. *The Cochrane Database of Systematic Reviews*, CD004853.

Wolf, R.S. (2000). The nature and scope of elder abuse. *Generations*, *24*(2), 6-12.

Wolf, R.S. (2001). Support groups for older victims of domestic violence. *Journal of Women & Aging, 13*(4), 71-83.

World Health Organization. (2011). *Elder maltreatment fact sheet N 357*. Retrieved from: http://www.who.int/mediacentre/factsheets/fs357/en/

World Health Organization. (2014). *Ageing and Life Course: Elder abuse*. Retrieved from: http://www.who.int/ageing/projects/elder_abuse/en/