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The Reality of Elder Abuse

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SUMMARY. There are two primary sources for understanding the reality of elder abuse. The first is empirical and derived from scientific study of its nature and scope. The second is experiential and illustrated in the perspectives of clinicians who detect and treat it along with victims who suffer its infliction and consequences. Both sources of understanding are evidenced in this overview of elder abuse as a health and social problem for older Americans. In addition, the article outlines the history in recognizing elder abuse as a problem and in developing strategies to address it.

KEYWORDS. Elder abuse, definition and forms, prevalence and incidence, risk factors, victim perspectives

UNDERSTANDING ELDER ABUSE

Elder abuse "came of age" as a recognized health and social problem during the1980s. However, its antecedents are found in two earlier periods, the first dating as far back as the mid-twentieth century.

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The expansion of public benefits in the 1950s enabled more older people to live on their own in the community. Professionals across service sectors, from banking and insurance to social work and law, became especially concerned about the growing number of mentally impaired older people living alone, often without nearby family support. It was feared that many could not provide for their own care or protection without community intervention (American Public Welfare Association, 1962; O'Neill, 1965). Dialogues at local and national levels on the need for protective services to address the potential neglect and exploitation of these vulnerable adults led to demonstration projects aimed at delineating the intervention and its clientele as well as evaluating its effectiveness (Horowitz & Estes, 1971; Blenkner et al., 1974; US Senate Special Committee on Aging, 1977). From this inception, adult protective services spread across the country during the mid-1970s, largely as a public agency responsibility, fueled by federal funding through Title XX of the Social Security Act (since 1981 incorporated into the Social Services Block Grant) (Brody, 1977; Regan, 1978).

The second antecedent period in recognizing elder abuse as a problem for older people sprang out of medicine, with four 1975 publications. Butler (1975) expressed alarm about "a battered old person syndrome" in his Pulitzer Prize-winning book *Why Survive? Being Old in America*; Clark, Mankikar, and Gray (1975) discovered a "Diogenes syndrome" wherein unkempt older people live in filth and debris and show no shame for their situation; and Baker (1975) and Burston (1975) in Great Britain labeled family members who physically abuse elderly relatives "granny batterers." Research on a broadening concept of elder abuse began shortly thereafter, with only a handful of studies completed by 1980 (Lau & Kosberg, 1979; Block & Sinnott, 1979; O'Malley et al., 1979; Douglass, Hickey, & Noel, 1980). These investigations were limited methodologically and focused primarily on exploring the forms of elder abuse and the characteristics of victims and perpetrators. Nonetheless, they were sufficient to trigger Congressional hearings on the subject along with increasing media coverage and presentations at professional associations (US House Select Committee on Aging and US House Science and Technology Subcommittee, 1978; US House Select Committee on Aging, 1980).

The 1980s are widely acknowledged as the decade for public awakening and broadening professional action regarding elder abuse (Wolf, 1988; Roybal, 1991). Certainly by the end of that decade elder abuse was recognized as a major issue of older Americans and an important aspect of family violence. Many of the key elder abuse studies were pub-

lished during the 1980s which shape our understanding of this phenomenon even today (e.g., Sengstock & Liang, 1982; Phillips, 1988; Wolf, Godkin, & Pillemer, 1984; Anetzberger, 1987; Pillemer & Finkelhor, 1988; Steinmetz, 1988). Several federal policies for addressing the problem were enacted, including provisions around elder abuse prevention, in Older Americans Act reauthorization and identification of older people as a potential targeted group for funding, in Family Violence Prevention and Services Act amendment. The majority of states and United States territories passed adult protective services or elder abuse reporting laws (Tatara, 1995). Finally, Haworth Press launched the *Journal of Elder Abuse & Neglect*, the Clearinghouse on Abuse and Neglect of the Elderly (CANE) was underway at the University of Delaware, the National Center for the Prevention of Elder Abuse was established, many state or local elder abuse coalitions were created, and numerous training or demonstration projects on elder abuse prevention or treatment were publicly funded (Wolf & Nerenberg, 1994).

Since the 1980s the field of elder abuse has sprung tentacles, reaching across systems, settings, and continents. For example, the growing criminalization of elder abuse has expanded the networks of involved practitioners to include those in law enforcement and domestic violence programs. With them has come particular interest in areas of financial abuse like telemarketing fraud, sexual assault in late life, and battered older women (Wilber & Reynolds, 1996; Tueth, 2000; Ramsey-Klawsnik, 1991; Simmelink, 1996; Harris, 1996; Brandl & Raymond, 1997). In addition, although awareness of elder abuse in nursing homes and other institutional settings began in the 1970s with exposes of deplorable conditions (Townsend, 1971; Stannard, 1973; Mendelson, 1974), it has heightened in recent years as a result of investigations by Long Term Care Ombudsman Programs and Medical Fraud Abuse Units (Huber, Netting, & Kautz, 1996; Payne & Cikovic, 1995). Likewise, research on elder abuse in such other countries as Canada, Finland, Israel, India, and Japan reveals that the problem is global (Podnieks, 1992; Kivela et al., 1992; Kosberg & Garcia, 1995), and an international perspective and response is required (United Nations Economic and Social Council, 2002).

Definitions and Forms

There is no universally accepted definitions or set of forms for elder abuse. Many different ones have been used by researchers studying the problem and policymakers enacting related laws. The result is a general

lack of comparability of research findings or state reporting statistics as well as confusion among practitioners and the public trying to understand elder abuse (Gelles & Cornell, 1985; Hudson, 1986; Wolf, 1988; Schene & Ward, 1988; Hudson, 1991).

Several controversies underlie the absence of universally accepted elder abuse definitions and forms. They include the following: How broad in meaning is elder abuse? Must there be intent for an act to be considered elder abuse? Does elder abuse always require a perpetrator? Who decides whether or not an act constitutes elder abuse? What is the onset age for elder abuse to occur? Should vulnerability of the victim be required in defining elder abuse? Do the effects, frequency, severity, or duration of the elder abuse play a role in defining the problem?

Some definitions of elder abuse limit themselves to a few select forms, and others include a wide range of forms. All elder abuse definitions used in research include physical abuse, and most also include neglect, psychological abuse, and financial abuse. Some research definitions incorporate sexual assault under physical abuse, and abandonment under neglect. Other times, these forms are investigated separately. Likewise, some research definitions separate neglect into two types, such as physical neglect and psychological neglect, or use the broader concept of exploitation and distinguish types within it, like financial abuse and violation of rights. Finally, many forms of elder abuse go by more than one name in the research literature. Psychological abuse, for instance, is sometimes referenced as emotional abuse or verbal abuse.

Like research definitions, definitions found in state elder abuse laws are most likely to include physical abuse, neglect, and financial abuse or exploitation as recognized forms. In fact, these forms are found in over three-fourths of the nation's 69 elder abuse laws (Tatara, 1995). Precise definitions are unique to each state. For example, Ohio's protective services law for adults (Ohio Revised Code 5105.60) contains definitions for abuse, exploitation, and neglect, i.e.,

- abuse: the infliction upon an adult by himself or others of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.
- exploitation: the unlawful or improper act of a caretaker using an adult or his resources for monetary or personal benefit, profit, or gain.
- neglect: the failure of an adult to provide for himself the goods or services necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods or services.

Although not expressly listed, Ohio's definition of abuse encompasses self-abuse, physical abuse, psychological abuse, and sexual assault. Exploitation addresses both financial abuse and violation of rights, and neglect includes self-neglect, physical neglect, psychological neglect, and some instances of abandonment. Moreover, acts of elder abuse must have consequences in order for them to come under the purview of Ohio law.

Federal policy on elder abuse is evident in the Older Americans Act, which includes definitions of the problem in the 1987 amendments. The Act recognizes physical abuse, neglect, and exploitation. However, the definitions of these forms are sufficiently broad to contain self-abuse, self-neglect, psychological abuse, and physical neglect as well.

No forms of elder abuse are more controversial than self-abuse and self-neglect. Some researchers and policymakers believe that the act of elder abuse requires a perpetrator, and the perpetrator must be someone other than the recipient of the elder abuse her/himself. They, therefore, exclude self-abuse and self-neglect from definitions of elder abuse, often considering them issues of inadequate care or support, which require different approaches for intervention than other elder abuse forms (Fulmer & O'Malley, 1987; Johnson, 1991). Still, 40 states have elder abuse laws that cover self-neglect, and Montana mandates the provision of services to self-neglecting older people, although it has no elder abuse law covering self-neglect (Tatara, 1995).

Since the mid-1980s research and public policy forums on elder abuse have recommended the adoption of elder abuse definitions that are clear, uniform, and relevant to practice (University of New Hampshire; 1986; Stein, 1991; US Department of Health and Human Services, 1992; Watson, 1995; National Research Council, 2003). Johnson (1986) and Hudson (1991) are recognized for their pioneering attempts to standardize elder abuse definitions through research. Hudson, for instance, conducted a three-round Delphi survey with a national panel of elder abuse experts to develop a taxonomy of elder abuse and definitions of related concepts. The result was a five-level taxonomy and eleven definitions. In the taxonomy Level I concerns violence involving older persons, Level II considers the relationship between victim and perpetrator, Level III relates to how the destructive behavior is carried out, Level IV surrounds the purpose motivating this destructive behavior, and Level V identifies the specific type of destructive behavior. Much of Hudson's subsequent research has expanded upon this study, comparing the perception of these national elder abuse experts in defining the problem to

public perceptions across ages and cultures (Hudson et al., 1998, 2000; Hudson & Carlson, 1999).

Widely accepted organizationally-based definitions also exist. For example, after analyzing federal and state elder abuse definitions in law, the National Center on Elder Abuse (1999) identified specific definitions for physical abuse, sexual abuse, emotional abuse, financial/material exploitation, neglect, abandonment, and self-neglect. At the state level, an Ohio team of researchers, operating under a statewide roundtable convened by the Ohio Department of Human Services (now called the Ohio Department of Job and Family Services), identified definitions for elder abuse and ten distinct forms. This occurred in the process of developing and testing screening tools and a referral protocol for service providers that involved practitioner key informant interviews, focus groups, and product application. The definitions are found in Figure 1 (Anetzberger et al., 1999; Anetzberger, 2001; Bass et al., 2001). These definitions for elder abuse, along with the specific definitions for abuse, neglect, and exploitation contained in Ohio law, will provide the framework for clinical analysis and management in the set of articles to follow.

Prevalence and Incidence

Because there has never been a national study on the prevalence of elder abuse in the United States, prevalence statistics offered for the problem tend to be based upon localized research. Collectively these studies suggest a prevalence rate between one and ten percent of the older people surveyed or older Americans as a whole (Lau & Kosberg, 1979; Block & Sinnett, 1979; McLaughlin, Nickell, & Gill, 1980; Gioglio & Blakemore, 1983; Pillemer & Finkelhor, 1988). Pillemer and Finkelhor (1988) conducted the best known and best regarded of the localized prevalence studies, surveying 2,020 randomly selected community-dwelling older persons in the metropolitan Boston area. Respondents were asked about three elder abuse forms: physical abuse, chronic verbal aggression, and neglect. Among the subjects, 3.2 percent experienced at least one form since age 65, with physical abuse (2.2 percent) more common than either verbal aggression (1.1 percent) or neglect (0.4 percent). Using somewhat similar methodologies but typically including financial abuse among the forms investigated, prevalence rates for elder abuse of between four and six percent were found in Canada, Great Britain, Finland, and the Netherlands (Podnieks, 1992; Ogg & Bennett, 1992; Kivela et al., 1992; Comijs et al., 1998). Financial abuse or verbal aggression tended to be more common than the other elder abuse forms in these studies.

FIGURE 1. Elder Abuse Forms and Definitions

Elder Abuse

- The infliction of injury or suffering on a person age 60 years or older by her/himself or another person.

Physical Abuse

- Abuse by others: Infliction of injury or pain on an older person by another person.
- Self-abuse: A form of physical abuse that occurs when an older person inflicts injury or pain on her/himself.
- Sexual abuse: Contact of a sexual nature that is forced, uninvited, or administered unknowingly through deception.

Psychological Abuse

- Infliction of mental anguish, use of threats, emotional abuse, forced witnessing of the abuse of others, isolation, or attacks against property and other acts of intimidation upon an older person by another person.

Neglect

- Physical neglect: Failure of a caregiver to provide an older person with necessary goods or services.
- Emotional neglect: Failure of a caregiver to provide adequate social or emotional support or stimulation to an older person.
- Abandonment: Desertion of an older person by a caregiver.
- Self-neglect: Failure of an older person to provide her/himself with necessary goods or services.

Exploitation

- Financial abuse: Unlawful or improper use of an older person's property or resources.
- Violation of rights: Denying an older person rights conferred on her/him by law or legal process.

After reviewing references in the Library of Congress, surveying state human services departments, and holding hearings on the problem, the US House Select Committee on Aging (1990) estimated that five percent of older Americans may be victims of moderate to severe elder abuse, resulting in around 1.5 million victims annually. Several years later the National Center on Elder Abuse (1997) projected 2.16 million elder abuse victims, with self-neglect included. The Center's figures considered both research and state reporting data.

The National Center of Elder Abuse (1998) also completed the first national incidence study on elder abuse, investigating the number of

unduplicated new cases of domestic elder abuse among persons age 60 and above in 1996. In conducting the research, it used a representative sample of 20 counties in 15 states and considered two data sources: reports to adult protective services and reports from sentinels (i.e., specifically trained individuals in community agencies having frequent contact with older people). The results of this study suggested a 1996 national elder abuse incidence rate of 551,011. Only 21 percent of the total were reported to and subsequently substantiated by adult protective services agencies. Of these, 38.4 percent represented self-neglect, 30.0 percent neglect, 21.8 percent emotional/psychological abuse, 18.6 percent financial/material exploitation, and 15.8 percent physical abuse.

As evident from the National Elder Abuse Incidence Study, most elder abuse is not reported to authorities charged with its investigation, like adult protective services. The US House Select Committee on Aging (1990) estimates that only one in eight cases are reported. However, based upon their Boston prevalence data, Pillemer and Finkelhor (1988) suggest that actual reporting may be even lower; perhaps only one in 14 elder abuse situations are ever reported to authorities.

Since the mid-1980s reports of domestic elder abuse to state adult protective services or aging agencies have steadily increased (Teaster, 2003). Nationwide 293,000 reports were received in 1996, compared to 117,000 in 1986, a 150.4 percent increase over a decade. Nearly two-thirds of reports were substantiated. One third of these cases were self-neglect or self-abuse, by far the most commonly reported forms of elder abuse and growing among reports received. From 1990 to 1996 reports of neglect (including self-neglect) increased while those of physical abuse, exploitation, and emotional abuse decreased. Reports of sexual abuse remained constant at 0.3 percent of total reports over this period (Tatara & Kuzmeskus, 1997; Tatara, 1996).

Reporting trends vary by state, with some states noticing declines in recent years. For instance, Ohio adult protective services agencies received 15,505 elder abuse reports in state fiscal year 1996, but only 12,194 in 2000, a decrease of over 25 percent. Among any ten elder abuse reports in Ohio, six tend to concern self-neglect, two surround neglect by a caregiver, and one each address abuse and exploitation. Within the period 1996-2000 reports of self-neglect increased, while those of abuse, neglect, and exploitation decreased (Ohio Department of Human Services, 1996; Ohio Department of Job and Family Services, 2000).

Reports of elder abuse come primarily from health and social services providers, especially those who offer care in the homes of older persons. Some practitioners, like visiting nurses and social work case

managers, are more likely to report than others, such as attorneys, members of the clergy, or physicians (Dolon & Hendricks, 1989; Blakely & Dolon, 1991; Rosenblatt, Cho, & Durance, 1996; National Center on Elder Abuse, 1997; Teaster, 2003).

There are many reasons why practitioners fail to report elder abuse, despite the fact that nearly all states mandate reporting by professionals (Tatara, 1995). These reasons include the following: lack of awareness about reporting responsibilities or elder abuse as a problem, perception that reporting abridges client confidentiality or destroys established rapport with the client, fear of litigation or other reprisal by the victim or perpetrator, lack of faith in the agency charged with handling the report or those providing services to protect the victim, or belief that reporting runs counter to such personal values as sanctity of the family (Gilbert, 1986; Fulmer & O'Malley, 1987; Thobaben, 1989; Daniels, Baumhover, & Clark-Daniels, 1989; Anetzberger, 1992; Coyne, Petenza, & Berbig, 1996).

Elder abuse laws with mandatory reporting provisions were enacted to foster professional case finding and referral to agencies responsible for assisting victims (Zborowsky, 1985; Regan, 1990). Various studies, however, suggest that mandatory reporting increases neither professional reporting nor the rate of elder abuse substantiation; rather, professional and public awareness is seen as key to case identification (Wolf, Godkin, & Pillemer, 1986; Fredriksen, 1989; US General Accounting Office, 1991).

Mandatory reporting provisions have been subject to controversy since they were first contained in elder abuse laws (Faulkner, 1982; Kapp, 1995). The controversy surrounding them includes the following: vague definitions for elder abuse identification, potential for inappropriately labeling persons as perpetrators, lack of adequate funding for proper law implementation, and undermining the autonomy of older people (Callahan, 1988; Blanton, 1989; Daniels, Baumhover, & Clark-Daniels, 1989; Macolini, 1995).

Elder Abuse Diagnosis and Risk Factors

Several theoretical perspectives have been suggested for understanding elder abuse (see Figure 2) (Phillips, 1986; Gelles, 1991; Nadien, 1995; Ansello, 1996; Aitken & Griffin, 1996; Wieche, 1998; Carp, 2000). Some are borrowed from the family violence literature explaining abuse against other populations, particularly children. Some have received support from empirical study, like psychopathology theory (Wolf, Godkin, & Pillemer, 1984; Anetzberger, 1987) and symbolic interactionism

(Steinmetz, 1988). Some have been collapsed into operational formulas for elder abuse interventions, such as situational, vulnerability, and exchange theories into the environmental press model (Ansello, 1996). However, none of the theoretical perspectives has been rigorously tested (National Research Council, 2003). In addition, with a problem as complex as elder abuse, it is unlikely that any single theoretical perspective could explain all forms and situations.

Lacking an established theoretical base for explaining elder abuse, research has focused on characterizing the victim and perpetrator, including identifying the risk factors which seem to increase the likelihood of abuse occurrence.

Summaries of research on elder abuse risk factors suggest that those related to the perpetrator are more predictive of abuse occurrence than those related to the victim. Johnson (1991) reviewed nine published works on elder abuse and ranked commonly identified characteristics for perpetrators and victims. There were at least four citations for each of the following perpetrator characteristics: psychopathology, stress/burnout, financial dependence, and dependencies other than financial. There was less consensus about victim characteristics, with only two receiving at least three citations: impairment and dependence. Lachs and Pillemer (1995) identified eight salient risk factors from the elder abuse literature, but concluded that the three most important factors rest with the perpetrator: substance abuse or mental illness, perpetrator dependence on the victim, and history of violence or extrafamilial antisocial behavior. The other five salient risk factors follow: poor health and functional impairment of the victim, cognitive impairment of the victim, shared living arrangements, external factors causing stress, and social isolation. Finally, from research using a validated assessment instrument, Reis and Nahmiash (1998) identified several risk factors related to the perpetrator, but only two related to the victim. For perpetrators in a caregiving relationship with victims, perpetrator risk factors include: substance abuse, mental health disorders, and behavioral problems; poor interpersonal relations; mental or family conflict; inexperience or reluctance to perform the caregiving role; lack of empathy or understanding for the care recipient; and financial dependence on the victim. Risks factors related to the victim are past elder abuse and lack of social support.

Various conceptual frameworks have been developed for viewing victim and perpetrator characteristics. An early one developed by Rathbone-McCuan and Hashimi (1982) focused on isolators (biophysical, psychological, economic, and social) in the lives of elder abuse victims.

FIGURE 2. Theoretical Perspectives for Understanding Elder Abuse

Conflict theory: Given imbalances in scarce resources, the potential exists for someone to take advantage of an older person.

Ecology theory: Abuse results from disorientation when sudden, unwanted change makes existing rules of behavior no longer workable.

Exchange theory: Older people are dependent upon those who abuse them out of a sense of power or power loss, but find the cost in terms of the abuse is less than a benefit of receiving care.

Feminist theory: Abuse against women results from structural inequities in society that disadvantage women.

Functionalism: Abuse exists because of cultural norms that leave few choices outside of the family to provide care for elderly members.

Psychopathology theory: Problems in psychosocial functioning can promote or provoke elder abuse.

Role theory: Elder abuse results from the inadequate, inappropriate, or unwilling provision of care.

Situational theory: Circumstances, such as social isolation or excessive stress upon a caregiver, can render an older person vulnerable to abuse.

Social learning theory: Abuse is learned from and reinforced by those of perceived authority.

Symbolic interactionism: Abuse is situationally defined and occurs in social interactions when there exist discrepancies between behaviors and role expectations.

Vulnerability theory: Impairment and incapacity can render older people at risk of abuse.

Anetzberger (1990) considered vulnerability to elder abuse as resulting from characteristics of the individual (personal, situational, environmental, and cultural) or characteristics of the system (inadequate funding, inappropriate services, and premature policy and practice). Lastly, Kosberg and Nahmiash (1996) identified characteristics of victims, perpetrators, and the abuse milieu in their conceptual framework. Those for victims include: gender, mental status, health, age, substance abuse, living arrangements, psychological factors, problem behaviors, dependence, and isolation. Those for perpetrators include: substance abuse, mental or emotional illness, lack of caregiving experience, reluctance, history of abuse, stress and burden, dependency, dementia, personality traits, and lack of social support. Characteristics for the milieu of abuse surround either the social context (financial problems, family violence, lack of social support, family disharmony, and living arrangements) or cultural

norms (ageism, sexism, attitudes toward violence, reactions to abuse, attitudes toward persons with disabilities, and family caregiving imperatives).

From research and reported cases a profile emerges of the typical elder abuse victim. In general that person is a woman age 75 or older who is widowed and living in her own home. She experiences more than one form of elder abuse, and has suffered multiple occurrences of the problem over time. Her perpetrator is a family member, usually either her adult child or spouse. That person also is typically male and living with the victim (e.g., Wolf, Godkin, & Pillemer, 1986; Tatara & Kuzmeskus, 1997; Lachs et al., 1997; National Center on Elder Abuse, 1998; Teaster, 2003).

There is recognition and some empirical evidence that risk factors and victim/perpetrator profiles vary by form of elder abuse (Steinmetz, 1988; Dolon & Blakely, 1989). For example, Wolf, Godkin, and Pillemer (1986) found differences in both for physical abuse, psychological abuse, material abuse, active neglect, and passive neglect in their research on three model elder abuse intervention projects. To illustrate, physical abuse victims tended to be younger, married, more independent in their functioning, in poor emotional health, and with stable social support. Their perpetrators had histories of mental illness or alcohol abuse, recent health decline, increased dependency, and poor relations with the victims. By contrast, victims of passive neglect tended to be older, unmarried, functionally impaired, and experiencing a loss of social supports. Their perpetrators lived with them, had unrealistic expectations, and had recent medical complaints. They also evidenced no financial dependency and had good relations with the victims. However, they found the victims to be sources of stress at a time they suffered from a loss of social support.

Anetzberger (2000) attempted to converge empirical data on both risk factors and victim/perpetrator characteristics to propose an explanatory model for elder abuse. The model has application to understanding elder abuse as it manifests itself across forms, settings, and relationships. It suggests that elder abuse is primarily a function of characteristics on the part of the perpetrator and secondarily on those of the victim. These merge and provide the underlying etiology for abuse occurrence. However, context is important as well, initially that which brings the victim and perpetrator together (such as spousal relations or adult children residing in the homes of elderly parents) and later that which triggers the occurrence of abuse (such as the repeated refusal of the victim to comply with caregiver expectations or the perpetrator being alone with easily accessible valuables).

However, beyond history and definitions, forms and statistics, theoretical perspectives and profiles are individual persons, each one experiencing elder abuse uniquely. The meaning of elder abuse for parties intimately involved in the problem is the focus of the sections which follow. Two perspectives are discussed: that of the clinician faced with elder abuse detection and intervention and that of the victim suffering its effects.

EXPERIENCING ELDER ABUSE

The Clinician's Perspective

Even to professional clinicians having experience in managing difficult client situations, elder abuse is perplexing, complex, and ethically charged. It can be hard to detect, with subtle manifestations or signs that mirror other problems or illnesses. It can seem impossible to control, particularly when the victim refuses help or denies the seriousness of mistreatment.

Elder abuse takes many different forms, and frequently does in any situation. It may involve more than one perpetrator and can continue or reoccur across time, and even across settings. Moreover, decision-making related to elder abuse interventions is rarely easy and is frequently clouded by ethical dilemmas. For example, deciding if and when to report an incident to authorities may be affected by numerous factors, including concern for possible repercussions against the victim or the effect of incorrectly labeling a perpetrator.

Beyond the dynamics of clinically managing elder abuse situations are the sensations and the emotions that they engender. Standing in a home inhabited by a self-neglecting elder person can be an assault upon the sense of smell. The stench of rotting garbage or flesh, animal defecation or urine-soaked mattresses, burnt furniture or moldy books can fill nasal cavities and remain in memory, and on clothing, long after the visit ends. Addressing caregiver neglect situations can leave clinicians emotionally spent–questioning how things deteriorated so badly, struggling to help victims understand their options, fearing the consequences of inaction, and wrestling with the concepts of autonomy versus safety in determining appropriate intervention.

Involvement in cases of physical abuse challenges the sense of sight. Open wounds, bruises at various stages of healing, and burnt skin may cover the color spectrum and make observers wince. They also can en-

gulf clinicians with an urgency that "something must be done now" and anger when it isn't. Psychological abuse bombards the sense of hearing with messages at once so damning and so incredible that clinicians may feel vulnerable themselves encountering them. Words that discredit, demean, or threaten rob victims' souls, leaving them feeling worthless, depressed, or anxious. They also can make clinicians feel like moral police for interfering and conspirators for not. Finally, situations of financial abuse tax the mind, searching for clues and solving puzzles. Hidden by family ties or among stacks of unpaid bills, evidenced only in the occasional missing check or altered document, financial abuse requires intellect to unravel and sometimes cultural distance to recognize amidst the American values of materialism, status, and individual acquisition that often foster it.

Reactions to elder abuse among clinicians are far-ranging. Some are repulsed by such situations. They want nothing to do with them, occasionally blaming the victims as either bringing the problem on themselves or capable of resolving it, if they only tried. Other clinicians have filters–cultural, professional, or personal–which enable them to encounter elder abuse situations and somehow remain oblivious to their damaging, potentially lethal, consequences. Still others follow legal mandates or professional standards, educating themselves about elder abuse and reporting it when necessary, but electing to keep a distance. For them, the nature of the problem is too horrendous or consuming to allow it more than minimal entry into the psyche.

There are some clinicians, however, albeit fewer than are needed, for whom addressing elder abuse is a calling and a passion. Within the context of their chosen professions, they have committed themselves to understanding the problem and taking whatever measures are appropriate to identify, prevent, and treat it. Colleagues often fail to comprehend a calling or passion for a problem always challenging, and frequently disheartening. They recognize that there are no simple cures or easy wins with elder abuse. There are even fewer expressions of gratitude. Accusations of intrusiveness are more likely. These colleagues know that it can be frightening to be wrong in assessing elder abuse, but perhaps less so than being right. Furthermore, most situations require considerable time and skills typically not employed in customary care or service delivery.

For clinicians who have committed themselves to addressing elder abuse as a calling, there are rewards, although they may not be publicly recognized or acknowledged. Focusing on social workers who provide adult protective services, McLaughlin (1988:32) concludes:

> Perhaps the most reported attribute of a skilled and effective protective service worker is taught in no university. It can't be found in any book or journal article. That attribute is courage. To successfully fulfill their responsibility to the victims of elder abuse, practitioners need the courage to allow competent clients to define for themselves what constitutes appropriate services. They need the courage to respect their client's wishes in the face of criticism from family members, the media, and powerful people in the community.

The difficulty of courageously managing elder abuse situations was recognized in the original development of adult protective services as a means to assist older people incapable of caring for themselves and lacking others able to provide support. In discussing the Benjamin Rose Institute's demonstration Protective Service Project, Wasser (1971: 521) noted "that the practitioner functions with a dual stream of opposing incentives, that of dealing with a protective client as a self-determining adult and, simultaneously, as one for whom serious interventions are required if he is to be helped to bring his disturbed and disturbing behavior under control." Unfortunately, serious interventions can be constrained by inadequate or inappropriate community resources or by unrealistic demands upon the time of the protective services workers (Anetzberger, 1990; Mixson, 1995). They also can be hampered by voluminous paperwork, personal and professional isolation, or role conflict, as protective services workers struggle between investigation/law enforcement and the provision of social services (Wynkoop & Gerstein, 1993; Otto, 2000).

The rewards for affording protection to elder abuse victims often tend to be intrinsic and reside in philosophical concepts of personal, societal, or religious importance, such as beneficence and justice (Johnson, 1999). They relate to a desire to "do good" or "make a difference," recognizing that the definition of these concepts varies by individual and situation. Furthermore, for those who chose the helping professions, reward also rests in risk reduction for vulnerable persons. The danger and extreme need of many elder abuse victims provide compelling justification for protective intervention. With the reduction or elimination of danger or need can come enormous personal satisfaction and sense of accomplishment for the clinician.

The Victim's Perspective

The meaning of elder abuse to victims has been captured in a variety of ways. Coverage by the mass media encompasses scenes of extreme

neglect, including footage of sordid living conditions and courtroom proceedings against perpetrators, such as those presented by television's "20/20" on March 19, 1999 of the physical neglect and exploitation of former boxer Jimmy Bivens. Film portrayals include interviews with physical abuse victims, such as Terra Nova Film's seven-year chronology of Norman's physical abuse principally by his oldest son in "I'd Rather Be Home." Public testimonies cover the range of elder abuse forms and have been given during hearings conducted at every governmental level, including the US Congress from the 1970s onward.

Collectively these scenes, portrayals, and testimonies suggest that elder abuse situations are not the same. Each has its own origins and dynamics. Each impacts its victim distinctively, reflecting the uniqueness of that individual's background, personality, and circumstances. However, there are certain commonalities shared by victims that bear noting in any discussion on the reality of elder abuse. These commonalities are evidenced in the consequences or effects of elder abuse on victims. Furthermore, they are seen in the responses of victims to the infliction of abuse or neglect.

Anetzberger (1997) offers a conceptual framework for understanding the effects of elder abuse upon victims. It suggests that the meaning of abuse is influenced by the victim's cultural background, cohort grouping, and individual experiences. Meaning is modified by the nature of the abuse (including its type, severity, and duration), the victim's relationship with the perpetrator, and personal circumstances (such as social support network and disability status).

The importance of culture on the meaning and response to elder abuse has received increased attention in recent years (Stein, 1991; Archstone Foundation, 1998; Tatara, 1997, 1999). The findings of numerous studies across various cultural groups suggest that ethnic background, and such other cultural factors as sexual orientation and gender socialization, may result in differences in how victims define elder abuse and their help-seeking behavior (Brown, 1989; Griffin, 1994; Tomita, 1994; Nagpaul, 1997; Chang & Moon, 1997; Sanchez, 1999; Hudson & Carlson, 1999; Moon, Tomita & Jung-Kamei, 2001). For example, Moon and Williams (1993) found that Korean-American elders have a narrower definition of elder abuse and a greater reluctance to seek help than either Caucasian Americans or African-Americans. In addition, Cook-Daniels (1997) suggests that older gays and lesbians may be more vulnerable to elder abuse as a result of an unwillingness to seek assistance from social service providers after years of hiding and living in a homophobic environment. Even within ethnic or other cul-

tural groups, meaning attached to elder abuse may vary by locale, history, or socioeconomic status (Krassen Maxwell & Maxwell, 1992; Hudson et al., 1998). For instance, Hudson and her associates (2000) observed within-group differences in the assessment of elder abuse vignettes among five Caucasian American groups in North Carolina.

Similarly, the collective values, attitudes, and experiences of a cohort or peer group can express themselves on the meaning and response victims give to elder abuse (Ramsey-Klawsnik, 1991; Anetzberger, Korbin, & Tomita, 1996). For example, today's elderly adults' connection with two World Wars and the Great Depression has resulted in an emphasis on social harmony, attachment to authority, and selfless contribution (Strauss & Howe, 1991), which may render them more willing to excuse violent behavior and remain in abuse situations if they believe that doing so promotes family stability or reflects religious doctrine.

The effects of elder abuse appear to assume four possible dimensions: physical, behavioral, psychological, and social (Lau & Kosberg, 1979; O'Malley et al., 1979; Sengstock & Liang, 1982; Pillemer, 1985; Hwalek, 1987; Quinn & Tomita, 1997; Anetzberger, 1997; Wolf, 1997). Besides injury or pain, physical effects include sleep disturbances, eating problems, and headaches. Behavioral effects include anger, helplessness, reduced coping, and suicidal actions. Psychological effects can be wide-ranging and include denial, fear, anxiety, and depression. Finally, social effects include dependence, withdrawal, and fewer contacts.

Little research has focused on the consequences of elder abuse (Wolf, 1997; National Research Council, 2003). Most evidence of its occurrence and typology comes from clinical records, case studies, or victim comment. Early investigations on elder abuse effects explored resulting depression (Phillips, 1983; Bristowe & Collins, 1989). For instance, in a comparison group study of elderly victims and nonvictims, Pillemer and Prescott (1989) found that victims of physical abuse, neglect, and chronic verbal aggression reported much higher levels of depression. Likewise, depression emerged as a consequence of marital violence among an elderly subsample from the National Family Violence Resurvey data (Harris, 1996). Netherlands research comparing elder abuse victims and non-victims showed more psychological distress among victims, with social support emerging as a favorable moderator (Comijs et al., 1999). In addition, Osgood and Manetta (2000-2001) studied older women who had been patients in psychiatric facilities and discovered that those who had thought about or attempted suicide were more likely to have been victimized by battery, rape, or child abuse. How-

ever, the consequences of abuse for older adults may be less than it is for younger adults. In comparing older and younger female trauma victims, Acierno and his associates (2002) found a lower incidence of depression and posttraumatic psychopathology among older victims.

Focusing on the physical effects of elder abuse, it is estimated that nearly 50 percent of all incidents result in physically apparent trauma (Floyd, 1984; Jones, 1988). As seen in hospital emergency departments, the most common manifestations of neglect are dehydration and malnutrition, and the most common physical injuries are bruises, lacerations, head injury, and fractures (Jones, 1990).

Victim response to elder abuse can range from denial or concealment to leaving the abusive situation or contacting authorities charged with investigating the problem. Research on victim response is as minimal as that on elder abuse effects. However, agency statistics and antidotal evidence suggest that few victims personally seek help for themselves from adult protective services, and fewer still elect emergency shelter through domestic violence programs (Salend et al., 1984; Nerenberg, 1996; National Center on Elder Abuse, 1998; Grossman & Lundy, 2003). Some studies indicate that older adults of Asian or Hispanic backgrounds prefer turning to family or friends for assistance, while African-Americans turn to others, such as formal service providers or the police (Moon & Williams, 1993; Anetzberger, Korbin, & Tomita, 1996).

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