Series Foreword

Exposure to traumatic events is all too common. Trauma increases the risk for a range of significant mental health problems, such as posttraumatic stress disorder (PTSD) and depression; physical health problems; negative health behaviors, such as smoking and excessive alcohol consumption; impaired social and occupational functioning; and overall lower quality of life. As mass traumas (e.g., September 11, military engagements in Iraq and Afghanistan, natural disasters such as Hurricane Katrina) have propelled trauma into a brighter public spotlight, the number of trauma survivors seeking services for mental health consequences will likely increase. Yet despite the far-ranging consequences of trauma and the high rates of exposure, relatively little emphasis is placed on trauma education in undergraduate and graduate training programs for mental health service providers in the United States. Calls for action have appeared in the American Psychological Association's journal *Psychological Trauma: Theory, Research, Practice, and Policy*, with such articles as "The Need for Inclusion of Psychological Trauma in the Professional Curriculum: A Call to Action," by Christine A. Courtois and Steven N. Gold (2009); and "The Art and Science of Trauma-Focused Training and Education" by Anne P. DePrince and Elana Newman (2011). The lack of education in the assessment and treatment of trauma-related distress and associated clinical issues at undergraduate and graduate levels increases the urgency to develop effective trauma resources for students as well as postgraduate professionals.

This book series, Concise Guides on Trauma Care, addresses that urgent need by providing truly translational books that bring the best of trauma psychology science to mental health professions working in diverse settings. To do so, the series focuses on what we know (and do not know) about specific trauma topics, with attention to how trauma psychology science translates to diverse populations (diversity broadly defined, in terms of development, ethnicity, socioeconomic status, sexual orientation, and so forth). Books in the series will address a range of assessment, treatment, and developmental issues in trauma-informed care. This series represents one of many efforts undertaken by Division 56 (Trauma Psychology) of the American Psychological Association to advance trauma training and education (e.g., see https://www.apa.org/ed/resources/trauma-competencies-training.pdf).

We are pleased to work with Division 56 and a volunteer editorial board to develop this series, which continues to advance with the publication of this important guide on elder abuse by Shelly L. Jackson. As clinicians, researchers, and policymakers increasingly turn their attention to the problem of older adult abuse and exploitation, Jackson offers a practical and accessible overview of the empirical literature. Her review of empirical work on older adult abuse integrates essential information about a host of clinically relevant topics, including reporting considerations. This practical book, grounded in research, will be of great use to mental health professionals working with older adults.

Anne P. DePrince
Ann T. Chu
Series Editors

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Introduction and Overview of Elder Abuse

Given that 10,000 baby boomers turn 65 each day (Cohn & Taylor, 2010) and the power of the baby boom generation to compel social change (Van Duizend, 2008), clinicians (mental health professionals) are increasingly likely to encounter victims of elder abuse in the course of their practice or become aware of an abusive situation involving one of their clients. They will be expected to respond appropriately.

Clinicians are well-poised to meet the growing demand for expertise on preventing, identifying, and ameliorating elder abuse. Nevertheless, clinical interventions to effectively address elder abuse require greater attention and development (Moore & Browne, 2016). Specifically, interventions to help victims heal and reduce their risk of revictimization are needed, as well as interventions to alter offenders' behavior. Family therapists are needed to develop and supply therapeutic interventions when family dynamics are involved.

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Understanding Elder Abuse: A Clinician's Guide, by S. L. Jackson

As the likelihood of dementia in older adults increases with age (Plassman et al., 2007), and its prevalence is expected to grow in the coming decades (Prince et al., 2013), psychologists and neuropsychologists must generate better means of assessing the older adult's capacity in a range of domains (Blum, 2015; Demakis, 2013a; Moye & Braun, 2010), including financial capacity (Gibson & Greene, 2013; Lichtenberg, 2016; Moye & Marson, 2007), as well as provide assessments to guide guardianship proceedings (Demakis, 2012, 2016; Gibson & Greene, 2013) and determine vulnerability (Wood & Lichtenberg, 2017). Already, neuropsychologists are being recruited to serve on multidisciplinary teams that supply in-home neuropsychological evaluations of elder abuse victims (Wiglesworth, Kemp, & Mosqueda, 2008).

As more of these cases enter the criminal justice system (Navarro, Gassoumis, & Wilber, 2013), forensic psychologists can also play a critical role by conducting psychological evaluations of elder abuse offenders, providing related expert testimony (Rom-Rymer, 2006), and educating criminal justice professionals (e.g., judges) about elder abuse (Howze & White, 2010). Research and analysis by clinicians can also contribute to relevant law and policy pertaining to elder abuse (Brank, 2007; Gibson & Greene, 2013). These examples are but a few of the ways clinicians can make a positive contribution to the emerging field of elder abuse (see Gatz, Smyer, & DiGilio, 2016).

Elder abuse has occurred throughout history (Teaster, Wangmo, & Anetzberger, 2010). However, private and public attention to elder abuse is quite recent, beginning in the 1970s. Elder abuse is now a recognized phenomenon found around the world (Phelan, 2013). As of 2010, 13.0% of the U.S. population was age 65 and older, with this group expected to compose 19.3% of the population by 2030 (U.S. Census Bureau, 2012). Of those aged 60 and older, it is estimated that just over 10% experience some form of elder abuse in a given year (Acierno et al., 2010; Lachs & Berman, 2011). As the population of older adults increases (U.S. Census Bureau, 2012), so too will the numbers of those affected by elder abuse.

Although still few, there have been modest political and empirical gains since the landmark release of the Institute of Medicine's (IOM's)

Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America (Bonnie & Wallace, 2003), which depicted the deplorable condition of the elder abuse field (e.g., Payne, 2011). The Elder Justice Act was enacted in 2009; it is the only federal legislation devoted exclusively to the problem. However, research is still in the nascent stage (Pillemer, Connolly, Breckman, Spreng, & Lachs, 2015), and Moore and Browne (2016) lamented that prevention has been all but ignored (see Nerenberg, 2008, for an exception). Furthermore, the research has been uneven, with less empirical attention to caregiver neglect (IOM, 2014) and psychological–verbal abuse (Fulmer, Rodgers, & Pelger, 2014) compared with other forms of elder abuse.

What is known about elder abuse, however, forms the substance of this book, which is designed to enable clinicians to better meet the needs of their older clients.[1] This book imparts a basic understanding of elder abuse, including risk and protective factors, the importance of cognition and capacity in this context, unique communication issues, clinicians' legal and ethical obligations, what to expect when interfacing with adult protective services (APS), available screening instruments, and current interventions. The goal is to enable clinicians to recognize and respond appropriately should they encounter an older adult who is or may be the victim of elder abuse.

The remainder of this chapter provides a broad introduction to elder abuse, including definitions, prevalence, theories, and consequences. It ends with an overview of the book.

ELDER ABUSE DEFINITIONS

Initially describing primarily physical abuse, the definition of *elder abuse* has evolved and expanded over time (Mysyuk, Westendorp, & Lindenberg, 2013). According to the Centers for Disease Control and Prevention (CDC;

[1] This book focuses on elder abuse occurring in domestic settings, as most clinicians will not interact with residents of long-term care facilities that primarily house the most vulnerable older adults (Castle, Ferguson-Rome, & Teresi, 2015). In addition, the federal regulation overseeing institutional settings is vast and distinguishable from policy targeting abuse in domestic settings. Assisted living and in-home care are largely unregulated (Greene, Lepore, Lux, Porter, & Freeland, 2015).

2016a), elder abuse is "an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult" (p. 28). In their seminal report, Bonnie and Wallace (2003) similarly defined *elder mistreatment* as

> (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. (p. 1)

One controversial aspect of these definitions is the question of whether a "trust" relationship must be present to constitute elder abuse. Conceptually, elder abuse would seem to exclude offenses perpetrated by strangers. However, Goergen and Beaulieu's (2013) eloquent analysis of this conceptualization argues that, at times, offenses perpetrated by people who are initially strangers can constitute elder abuse. For example, a dyad may meet online, and although initially strangers, part of the grooming involves becoming acquainted and eventually intimate (emotionally if not physically), as in romance scams. Although the CDC (2016a) recently released definitions, the field continues to struggle over how to define elder abuse. Garre-Olmo et al. (2009) defined elder abuse as "any action or any lack of appropriate action that causes harm, intentionally or unintentionally, to an elderly person" (p. 815), suggesting age alone is the defining characteristic of elder abuse. Age as the defining feature of elder abuse is no more controversial among professionals than it is among older adults (Mouton et al., 2005). At the most restrictive end of the spectrum, however, is Dong and Simon's (2010) definition that requires three elements: (a) older age, (b) vulnerability, and (c) the presence of a trust relationship (p. 744). This volume uses the CDC's (2016a) definition of elder abuse, necessitating the presence of a trusting relationship between the victim and offender. This definition includes not only family members but also friends, paid caregivers, financial advisors, and other professionals, depending on the situation.

Further complicating the definition is that elder abuse is a rubric under which typically five forms of elder abuse are subsumed (Dong, 2014). These

five forms are financial exploitation, caregiver neglect and abandonment, psychological abuse, physical abuse, and sexual abuse. According to the CDC (2016a),[2] *financial exploitation* is defined as the illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual. This includes depriving an older individual of rightful access to, information about, or use of personal benefits, resources, belongings, or assets. Signs and symptoms of financial exploitation include but are not limited to

- missing money or valuable possessions;
- appearance of previously uninvolved relatives;
- adding names on a bank account or bank signature card;
- unauthorized use of an ATM card;
- changes in a will or other financial documents; and
- unpaid bills, although there are sufficient resources.

Caregiver neglect is defined as failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health or safety, relative to age, health status, and cultural norms. *Abandonment* has been conceptualized as an extreme form of neglect involving the desertion of a vulnerable older adult by anyone who has assumed the responsibility for care or custody of that person. Signs and symptoms of caregiver neglect include but are not limited to

- dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- unattended or untreated health problems;
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no heat, no running water);

[2] In the past, abrogation of basic constitutional rights (e.g., restriction on freedom of movement; Kapp, 1995) were also considered a form of elder abuse, but that concept has disappeared in the literature.

- unsanitary and unclean living conditions (e.g., dirt, fleas, lice, soiled bedding, human or animal fecal/urine smell, inadequate clothing); and
- the desertion of an older adult at a hospital, a nursing facility, or other public place.

Physical abuse is defined as the intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death. Signs and symptoms of physical abuse include but are not limited to

- bruises, black eyes, welts, cuts, and rope marks;
- broken bones, bone fractures, and skull fractures;
- open wounds, cuts, punctures, and untreated injuries in various stages of healing;
- sprains, dislocations, and internal injuries/bleeding;
- broken assistive devices (eyeglasses, dentures, walker); and
- using prescription drugs in ways other than prescribed (over- or underuse).

Psychological abuse is defined as verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress, that is perpetrated by a caregiver or other person who stands in a trust relationship to the elder.[3] Such behaviors may have immediate effects or delayed effects that are short or long term in nature that may or may not be readily apparent to or acknowledged by the victim. They may include any of the following and vary according to cultural norms: humiliation/disrespect, threats, harassment, or isolation/coercive control. Signs and symptoms of psychological abuse include, but are not limited to

- visibly emotionally upset or agitated;
- extremely withdrawn and noncommunicative or nonresponsive;
- unusual behavior usually attributed to dementia (e.g., sucking, biting, rocking); and
- the caregiver's refusal to allow visitors to see an older adult alone.

[3] The term *psychological abuse* is used in this volume, although studies sometimes use the terms *emotional* or *verbal abuse*.

Sexual abuse is defined as forced and/or unwanted sexual interaction (touching and nontouching acts) of any kind with an older adult. Signs and symptoms of sexual abuse include, but are not limited to

- bruises around the breasts or genital area;
- unexplained venereal disease or genital infections;
- unexplained vaginal or anal bleeding; and
- torn, stained, or bloody underclothing.

Self-Neglect

There is some debate in the field about whether *self-neglect* falls under the rubric of elder abuse (Payne & Gainey, 2005). Self-neglect is defined as an adult's inability, because of physical or mental impairment or diminished capacity, to perform essential self-care tasks, including (a) obtaining essential food, clothing, shelter, and medical care; (b) obtaining goods and services necessary to maintain physical health, mental health, or general safety; and/or (c) managing one's own financial affairs (Teaster et al., 2006). Many state statutes include self-neglect in their response to elder abuse, and it is a significant part of an APS caseworker's caseload (Teaster et al., 2006). There also is evidence that self-neglect is related to other forms of elder abuse, either as a consequence of other forms of victimization or creating a vulnerability for which an abusive individual might take advantage (Dong, Simon, & Evans, 2013; Dong et al., 2009). However, self-neglect does not involve a relationship obliged by the typical definition of elder abuse, and therefore the CDC (2016a) excludes self-neglect as a form of elder abuse. This is the position adopted in this volume.

Distinguishing Elder Abuse From Other Harms

As presented in Figure 1.1, elder abuse is distinguishable (albeit overlapping) from other harms against older adults (Heisler, 2015). Elder abuse comprises five forms: caregiver neglect and physical, financial, psychological, and sexual abuse. In contrast, *abuse in later life* forms a subset of elder abuse by its focus on domestic violence and sexual assault of older

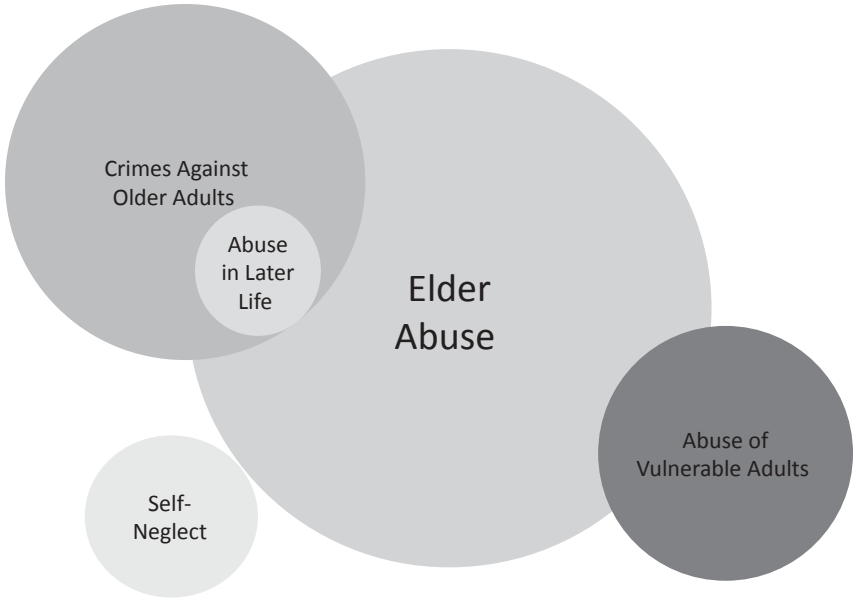

Figure 1.1

How elder abuse is distinguishable from, yet overlaps with, other harms against older adults (based on definitions in Heisler, 2015).

adults (Crockett, Brandl, & Dabby, 2015; Penhale, 2003). Thus, although overlapping to a degree with elder abuse, abuse in later life is considerably narrower and typically espouses its own theoretical position (Brandl, 2002). *Crimes against older adults*, such as burglary, assault, financial scams, and identity theft, are typically perpetrated by a stranger rather than a trusted person and therefore are typically excluded from the rubric of elder abuse (Burnes et al., 2017; Policastro, Gainey, & Payne, 2015). In addition, crimes against older adults usually garner greater attention from the discipline of criminal justice than from social work or gerontology (Payne, 2002). *Abuse of vulnerable adults* encompasses individuals ages 18 years and older with some statutorily defined vulnerability (Hughes, Lund, Gabrielli, Powers, & Curry, 2011). Thus, there is again some overlap with elder abuse given that some older victims also exhibit vulnerability, but because the category includes younger adults as well, it is distinct from elder

abuse. In addition, as described earlier, elder abuse is distinguishable from self-neglect because there is no perpetrator involved.

PREVALENCE OF ELDER ABUSE

Only recently has the field been able to estimate the prevalence of elder abuse, although ongoing surveillance eludes the field (Jackson, 2017b; U.S. Government Accountability Office, 2011). As mentioned earlier, it is estimated that just over 10% of this country's adults aged 60 and older experience some form of elder abuse in a given year (Acierno et al., 2010; Lachs & Berman, 2011), although prevalence varies by the type of abuse involved: financial exploitation (5.2%), caregiver neglect (5.1%), emotional/psychological abuse (4.6%), physical abuse (1.6%), and sexual abuse (< 1.0%; Acierno et al., 2010). Although prevalence studies have been undertaken in countries around the world, these studies are not comparable because of differences in definitions, methodologies, and instruments (Cooper, Selwood, & Livingston, 2009). However, across prevalence studies, psychological abuse appears to be the most prevalent form of elder abuse (Jackson, 2016c). On the basis of APS data, between 30% and 40% of reported abused older adults experience more than one type of abuse simultaneously (Clancy, McDaid, O'Neill, & O'Brien, 2011; Teaster et al., 2006), sometimes referred to as *poly-victimization* in later life.

Very little research has included minority populations, even though approximately 20% of older adults are minorities: 8.4% African American, 6.9% Hispanic origin, 3.5% Asian or Pacific Islander, and 1% American Indian or Native Alaskan (U.S. Census Bureau, 2012). However, there is some evidence that rates of some types of abuse are higher among minority populations. Several studies have found that African American individuals are more likely to be financially exploited than Caucasian American individuals (Beach, Schulz, Castle, & Rosen, 2010; Laumann, Leitsch, & Waite, 2008; Peterson et al., 2014). For example, in a county-level self-report prevalence study, Beach et al. (2010) found that in the past 6 months, 12.9% of African American individuals were financially exploited compared with

2.4% of non–African American individuals. In addition, it has been suggested that among Native Alaskan persons, financial exploitation is the most frequently reported form of elder abuse (Graves, Rosich, McBride, Charles, & LaBelle, 2010). In a convenience sample of Latino immigrants residing in Los Angeles, California, using *promotores* (specially trained lay community members who provide health care education to community members), 40.4% had experienced some type of elder abuse in the previous year (DeLiema, Gassoumis, Homeier, & Wilber, 2012), a rate significantly higher than nationally representative prevalence studies find, although this higher rate is accounted for in part by the voluntary nature of the sample.

LOCATION OF ELDER ABUSE

Although elder abuse occurs in long-term care facilities (Castle, Ferguson-Rome, & Teresi, 2015), and these instances certainly receive more political attention (Jackson, 2017b), the majority of reported elder abuse (89.3%) occurs among older adults residing in the community (Clancy et al., 2011; Teaster et al., 2006), most typically in their place of residence. Contrary to stereotypes of aging, the majority (95%) of older adults reside in the community (U.S. Census Bureau, 2012). In fact, only 3.6% (1.5 million) of older adults aged 65 and older reside in a nursing home (Administration on Aging, 2012). However, the proportion clearly increases with age: 15.1% are under age 65, 16.1% are ages 65 to 74, 27.2% are ages 75 to 84, and 41.6% are ages 85 or older (CDC, 2016b, p. 105).

UNDERREPORTING OF ELDER ABUSE

There is a broad consensus that elder abuse is underreported. A comparison of self-reported abuse to official reports in New York state concluded that one in 24 cases of elder abuse is reported to authorities (Lachs & Berman, 2011). However, there were differences depending on the type of abuse involved: one in 57 cases of neglect, one in 44 cases of financial

exploitation, one in 20 cases of physical abuse/sexual abuse, and one in 12 cases of psychological abuse were reported to a state authority.

REVIEW OF EXISTING THEORIES

Elder abuse research is characterized by an absence of theory (National Institute of Justice [NIJ], 2014). Furthermore, when theory is invoked, the theories are frequently borrowed or adapted from the fields of child abuse or intimate partner violence. Kapp (1995), however, censured the field for borrowing concepts, asserting that elder mistreatment is a "unique problem" (p. 379). More recently, scholars have admonished the field for failing to develop elder abuse theories, generally (Bonnie & Wallace, 2003), and for distinct types of abuse, specifically (Jackson & Hafemeister, 2013d). Different theories implicate different interventions (Eisikovits, Koren, & Band-Winterstein, 2013; Jackson & Hafemeister, 2013d; Payne, 2011). For example, if it is believed that the underlying cause of elder abuse is patriarchy, the intervention might include correcting misperceptions through intensive psychoeducation for abusers as observed in the intimate partner violence field (Gondolf, 2011). Alternatively, if abusers have unresolved psychological problems, then the intervention might include addressing those unresolved problems through psychotherapy (Dutton, 2006). If, on the other hand, abusers are deviant, then the criminal justice system may be the intervention of choice, as articulated by Pillemer (2005).

In their review, Burnight and Mosqueda (2011) concluded that elder abuse theories are predominately interpersonal in nature, although other applications involve sociocultural, macrolevel, and multisystemic approaches. On the basis of a review of the literature (Burnight & Mosqueda, 2011; IOM, 2014; NIJ, 2014; Payne, 2011; Wilber & McNeilly, 2001), a brief summary of the predominant theories is presented on the following pages. Note that many theories focus on physical abuse and hold little relevance for caregiver neglect, financial exploitation, or sexual abuse, perhaps because these adapted theories initially were developed to explain other phenomena.

Interpersonal Theories

Caregiver Stress Theory

Caregiver stress theory is perhaps the only theory originating within the field itself. Elder abuse occurs when family members caring for an impaired older adult are unable to adequately manage their caregiving responsibilities (Steinmetz, 1978). The older victim is typically described as highly dependent on the caregiver, who becomes overwhelmed, frustrated, and abusive because of the unrelenting caretaking demands posed by the dependent older person. Prominent in the 1970s, this unidimensional theory has fallen out of favor among scholars (Bonnie & Wallace, 2003), although practitioners continue to find this concept relevant (Sanders, 2016). To address caregiver stress, practitioners have focused interventions primarily on alleviating caregiver stress through respite care or teaching caregivers coping strategies (Doty, 2010). Caregiver stress interventions are unequivocally the most prevalent form of elder abuse intervention (Ayalon, Lev, Green, & Nevo, 2016).

Family Power-Dependent Relationship Model

Integrating concepts from gerontology and intimate partner violence, Ziminski Pickering and Phillips (2014) recently introduced a model for the development of aggression (physical and verbal) toward older parents by their adult children. The model posits that long before a caregiving situation arises, there exists a cognitively intact older adult and a dependent adult child. Families are by their nature interdependent, but at some point the adult child perceives a power deficit and uses aggression in an attempt to claim more power in the relationship. No elder abuse interventions have been developed based on this theory.

Intergenerational Transmission of Violence Model

The intergenerational transmission of violence theory, based on social learning theory, posits that abusive acts are a learned behavior transferred through the process of modeling (Bandura, 1973). Elder abuse occurs as a result of the abusive individual's having learned to use violence in an earlier familial context, either to resolve conflicts or to gain a desired outcome

(Wilber & McNeilly, 2001). Korbin, Anetzberger, and Austin (1995), however, found little empirical support for the intergenerational transmission model in the context of elder abuse. No elder abuse interventions have been developed on the basis of this model.

Social Exchange Theory

For the social exchange theory, practitioners argue that social behavior involves negotiated exchanges of material and nonmaterial goods. Abusive individuals perceive themselves as not receiving their fair share from a relationship with the older person and therefore resort to violence in an effort to restore or obtain equilibrium within the relationship (Decalmer & Glendenning, 1993). This theory may hold less relevance for elder abuse, particularly where parent–adult child relationships are at play in which choice is not the defining characteristic of the relationship (Rusbult & Van Lange, 2003). No elder abuse interventions have been developed on the basis of this theory.

Dyadic Discord Theory

The dyadic discord theory combines elements from two theories. Relationship discord results from a combination of contextual factors such as a history of family violence, which primes a person's acceptance of violence as a conflict resolution strategy (i.e., social learning theory), and situational factors such as a lack of relationship satisfaction (i.e., social exchange theory; Riggs & O'Leary, 1989). However, this theory may hold less relevance for an abusive situation involving an older parent and an adult child where the relationships tend to be more needs-based than contribution- or choice-based (Maccoby, 2000). No elder abuse interventions have been developed on the basis of this theory.

Sociocultural Theories

Power and Control Theory

The power and control theory posits that abusive individuals use coercive tactics to gain and maintain power and control during the course of a relationship with another individual (Yllo & Bogard, 1998). This feminist

theory asserts that because males have more power in our society, they are more likely to use coercive tactics to maintain control (Brandl, 2002). Dominant in the domestic violence field, the power and control theory has been critiqued for being unidimensional and its inability to explain the various subtypes of elder abuse. On the basis of this theory, psychoeducational interventions such as batterer intervention programs are prolific in the context of domestic violence (Gondolf, 2011), with only one such intervention targeting individuals who are physically abusive toward older women (Klein, Tobin, Salomon, & Dubois, 2008).

Routine Activities Theory

A frequently invoked theory to explain elder abuse is the criminological routine activities theory (RAT). Designed to explain opportunistic crime, the theory posits that crime results when there is (a) a suitable target, (b) an unguarded target, and (c) a motivated offender. Used primarily in the context of financial exploitation (e.g., Setterlund, Tilse, Wilson, McCawley, & Rosenman, 2007), a suitable target might be an older person who appears vulnerable in some way (i.e., suitable), particularly in the absence of a friend or family member (i.e., unguarded), who is in the presence of a motivated offender. When these three elements converge, elder abuse may occur. RAT has been critiqued, however, as rather superficial; for example, RAT does not address the motivation of the offender. However, it does offer simple solutions to crime prevention, such as providing oversight for older adults. Indeed, there is a call for adult children to play a greater oversight role in their parents' financial matters (Huddleston, 2011).

Macrolevel Theory

Ageism

Ageism involves negative attitudes toward older adults and contributes to apathy toward their maltreatment (Harbison, 2016; Phelan, 2008). Facets of ageism include talking with an older adult in a loud or baby voice or acting as a protector rather than an equal (Hagestad & Uhlenberg, 2005). Through the lens of ageism, it is argued that younger adults have power

based on their youth, whereas older individuals have less power based on their older age; therefore, younger adults perceive older adults as different and inferior. These negative stereotypes (e.g., useless, functionally impaired) limit both how younger adults view older adults and how some older adults perceive themselves. Individuals are more likely to invoke stereotypes with strangers than with people they know, such as their grandparents (Hagestad & Uhlenberg, 2005). Therefore, one antidote to ageism is simply exposure to older people. Indeed, perceiving ageism as detrimental to society, the World Health Organization (WHO) recently initiated the #YearsAhead campaign targeting the elimination of ageism by dispelling stereotypes through Instagram (WHO, 2015).

Multisystemic Models

Biopsychosocial Model

The biopsychosocial model asserts that elder abuse is attributable to multiple factors simultaneously. The causal mechanisms include the characteristics of both the older person and the abusive individual, each of whom is embedded in a larger sociocultural context (family and friends) and their status inequality, relationship type, and power and exchange dynamics (Bonnie & Wallace, 2003, p. 63). Although such a model provides ample points for intervention, it has not been empirically tested, and no elder abuse intervention based on this model has been developed.

Ecological Model

The ecological model posits that influences at the individual, relationship, community, and societal levels contribute to the occurrence of elder abuse (Schiamberg & Gans, 2000; Von Heydrich, Schiamberg, & Chee, 2012). For example, factors at the individual level might include the degree of dependency of the older adult and the degree of the adult child's impairment (e.g., substance abuse). At the relationship level, factors might include the quality of the relationship between the older adult and adult child. At the community level, factors might include the degree of neighborhood cohesion in which the older adult lives. Finally, at the societal level, factors

might include ageism or whether social policies are in place that facilitate older adults remaining in their own home and thus reducing their reliance on unsuitable family members for assistance. Interventions adopting this model might target pliable risk factors at the various levels. However, no such elder abuse intervention exists.

Is There a Predominant Theory?

It would be inaccurate to say that any one of these theories garners more support than another. As noted, the field is predominately atheoretical. Theories have typically attempted to explain "elder abuse" rather than forms of elder abuse. Furthermore, the role ethnicity plays in theory has been limited. Parra-Cardona, Meyer, Schiamberg, and Post (2007), however, adapted the ecological model to arrange risk factors among Latino families experiencing elder abuse. For example, factors at the individual level included the degree of dependency of the older adult but also their country of origin as well as the degree of the adult child's impairment (e.g., substance abuse). At the relationship level, factors included the quality of the relationship between the older adult and adult child as well as family distrust toward institutions. At the community level, factors included the degree of economic opportunity and limited access to institutional support in the community in which they live. Finally, at the societal level, factors included an anti-immigrant climate and economic instability. Clearly, there remain significant gaps in our understanding of elder abuse among minority populations (Moore & Browne, 2016).

CONSEQUENCES

Only recently have studies identified different types of harms that mistreated older persons may suffer. There is some evidence that consequences vary by subtype (Burnett et al., 2016; Dong & Simon, 2013a, 2013b). For example, Burnett et al. (2016) found higher rates of mortality for victims of caregiver neglect and financial exploitation compared with physical abuse

and psychological abuse. Nonetheless, the consequences of elder abuse routinely lead to a diminished quality of life for all abused older adults. Unfortunately, whether and how consequences of elder abuse differ across minority populations is currently unknown.

The consequences associated with elder abuse can be devastating and are typically categorized as psychological, social, health, financial, secondary victims, and costs to society (Bonnie & Wallace, 2003). Below is a brief review of research on these consequences, along with a discussion of consequences for undergoing an investigation by APS.

Psychological

Elder abuse can be characterized as a stressful life event or as a traumatic event resulting in psychological distress (Roepke-Buehler, Simon, & Dong, 2015). Although a sophisticated understanding of the psychological effects associated with elder abuse eludes us (although see Ogle, Rubin, & Siegler, 2013), across several studies, using different samples and measures, depression has been consistently associated with elder abuse. Roepke-Buehler et al. (2015) measured depression with the Center for Epidemiologic Studies Depression Scale (CES-D; Kohout, Berkman, Evans, & Cornoni-Huntley, 1993), while Dong, Simon, Odwazny, and Gorbien (2008) and Garre-Olmo et al. (2009) used the five-item Geriatric Depression Scale to measure depression. Dong et al. (2008) found that after adjusting for age and sex, participants with depression were more likely to report abuse and neglect. Cisler, Begle, Amstadter, and Acierno (2012) measured emotional symptoms with two unstandardized questions (i.e., a combination of emotional symptoms including anxiety, depression, or irritability, and functional impairment due to personal or emotional problems). Compared with physical and sexual abuse, emotional abuse (and history of prior trauma events exposure, poor physical health, younger age, low social support, and needing help with activities of daily living) was related to emotional symptoms (defined above), suggesting that emotional abuse has a more direct effect on mental health.

Social

Social consequences have also been identified, but much less is known about them. Disruptions in social and family relationships occur as a consequence of elder abuse (Jackson & Hafemeister, 2010), which can be psychologically devastating. For example, if family members are concerned about a loved one, but the older adult refuses to change their situation, family members may become angry or discouraged and cut off ties with the older adult (Breckman & Adelman, 1988).

Health

The health consequences of elder abuse are many. They may include compromised health (Gibbs, 2014), resulting directly or indirectly from elder abuse. For example, physical injury can result directly from physical abuse, sexual abuse, and caregiver neglect (Murphy, Waa, Jaffer, Sauter, & Chan, 2013). Several forms of elder abuse have been associated with hospitalization (Dong & Simon, 2013b) and even mortality (Dong et al., 2009; Burnett et al., 2016). Indirect effects of elder abuse on health might include, for example, when financial exploitation results in the inability to purchase medications or pay for health care services (Price, King, Dillard, & Bulot, 2011). Financial strain associated with financial exploitation may produce stress (Sapolsky, Armanini, Packan, & Tombaugh, 1987), which is associated with decreased mental and physical health (Kahn & Pearlin, 2006) and higher mortality (Szanton et al., 2008). Furthermore, recovery from the neglect or physical abuse tends to be more difficult for older adults who typically have fewer physical reserves (Horan & Clague, 1999).

Financial

The financial consequences are many as well. Victims of financial exploitation, for example, may experience major or minor financial loss (Holtfreter, Reisig, Mears, & Wolfe, 2014). Financial loss may occur in the form of cold cash but may extend to loss of assets including one's home (Jackson & Hafemeister, 2012b), with some older adults having to

move into senior subsidized housing (Jackson & Hafemeister, 2010). One issue many victims of financial exploitation face is tarnished credit scores and consequent difficulty obtaining credit or unrelenting calls from debt collectors (Deem, 2000). Furthermore, financial burden can be incurred through medical bills and the need to purchase new assistive devices as a result of other forms of maltreatment (Payne, 2011).

Secondary Victims

There are secondary victims as well. Family members are often aware of an ongoing abusive situation and must bear witness to it (Breckman & Adelman, 1988; Jackson & Hafemeister, 2015). In addition, family members may become financially responsible for older adults who have lost some or all of their life savings or who become dependent because of maltreatment that compromises their health or physical functioning (Bond, Cuddy, Dixon, Duncan, & Smith, 2000). Finally, for those who have lost their entire life savings, family members will have lost their inheritance.

Costs to Society

Elder abuse imposes significant costs to society as well. For example, there are many agencies that might respond to elder abuse (e.g., emergency medical technicians, civil legal assistance, aging services network), increasing the financial burden to society. Furthermore, as a result of financial exploitation, some older adults may become eligible for Medicaid, also increasing the costs to society (U.S. Senate Special Committee on Aging, 2011).

Consequences Associated With an APS Investigation

Perhaps more as a result of interfacing with the social services system than the experience of elder abuse per se (i.e., outcomes of an APS investigation), older victims may experience reductions or restrictions on their independence designed to increase their safety (Choi, Kulick, & Mayer, 1999). At the most extreme, this reduction might take the form

of imposition of a guardian (Jackson & Hafemeister, 2013b), perhaps the most draconian outcome for older adults as their decision-making freedom is stripped away (Wright, 2010). Changes in living arrangements also may occur—either institutionalization (Dong & Simon, 2013a) or some less extreme change, such as a new apartment (Clancy et al., 2011; Jackson & Hafemeister, 2013b). Either way, changes in living arrangements constitute a challenging adjustment for many older adults (Hooyman & Kiyak, 1988), especially those who have lived in the same home for decades with its familiarity and memories.

CONCLUSION

Considerable gains have been made in the field of elder abuse (research, practice, and policy) since the 1970s, with progress unequivocally accelerating since 2003. For example, the Elder Justice Act was passed in 2009; it was the first federal legislation devoted exclusively to elder abuse. However, elder abuse is not widely recognized as a social problem in our country, with the possible exception of financial exploitation (Jackson, 2016b). Although our knowledge base is growing, it remains uneven and incomplete. The field has yet to rally around a set of definitions, develop thoughtful and useful theories, or more carefully identify the consequences associated with elder abuse. Each of these gaps needs filling to more thoughtfully and effectively intervene in the lives of older Americans.

In the meantime, clinicians have older clients in need of assistance. In the chapters to come, clinicians will learn the practical lessons they did not learn in graduate school. This learning includes the risk and protective factors for elder abuse (Chapter 2); the important role of cognitive capacity and how to communicate with older adults who have cognitive or other impairments (Chapter 3); how to detect elder abuse and meet one's legal and ethical obligations upon detection (Chapter 4); how to work with APS (Chapter 5); and an overview of the most current elder abuse interventions that might be useful in clinical practice (Chapter 6). The immediate goal of this book is to enable clinicians to enhance their practice with victims of elder abuse, but ultimately, the goal is to enrich the lives of older adults by ensuring that the professionals who work with them are well prepared to do so.