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ELDER ABUSE AND NEGLECT

The American family has historically been viewed as a sacrosanct institution for care of the individual—the inviolate haven of love, safety, and protection. Growing awareness of family violence, however, has shown this view to be faulty, first with the “discovery” of child neglect and abuse in the 1960s, followed by spouse abuse in the early 1970s, and elder neglect and abuse in the mid-1970s. Yet, Peter Stearns and Shulamit Reinharz believe that family violence, in general, and elder mistreatment, specifically, have existed since the beginning of human history. Early examples of elder neglect and abuse include adult sons killing their aged parents in Teutonic societies and Native American tribes abandoning their elders when they can no longer travel (Sumner).

Acceptance of these historical facts as evidence depends on one’s definitions of elder abuse and neglect. The likelihood of disagreement is considerable, since these concepts are value-laden and typically trigger emotional responses before logical thought. In addition, the perception of violence varies from society to society, and culture to culture. William Sumner argues that either honor or destruction underpin societies. When it is the former, older adults are respected and honored, while with the latter they are viewed as societal burdens which sap the strength of the society. This negative view of older adults sets the stage for ageism and mistreatment.

Although mistreatment of older adults is probably not a new phenomenon, awareness that some elders are mistreated and interest in examining the problem are relatively new. Initial professional recognition occurred almost simultaneously in Great Britain and America. In 1975, G. R. Burston wrote of “granny bashing” and Robert Butler described the “battered old person syndrome.” In 1978 Suzanne Steinmetz shared her “discovery” of battered elders. Over the succeeding years as more cases were uncovered, initial disbelief and denial have given way to acknowledgment of the societal problems of

elder neglect and abuse. In the early 1980s, researchers began to investigate elder mistreatment, and the House Select Committee on Aging began a series of public hearings around the country.

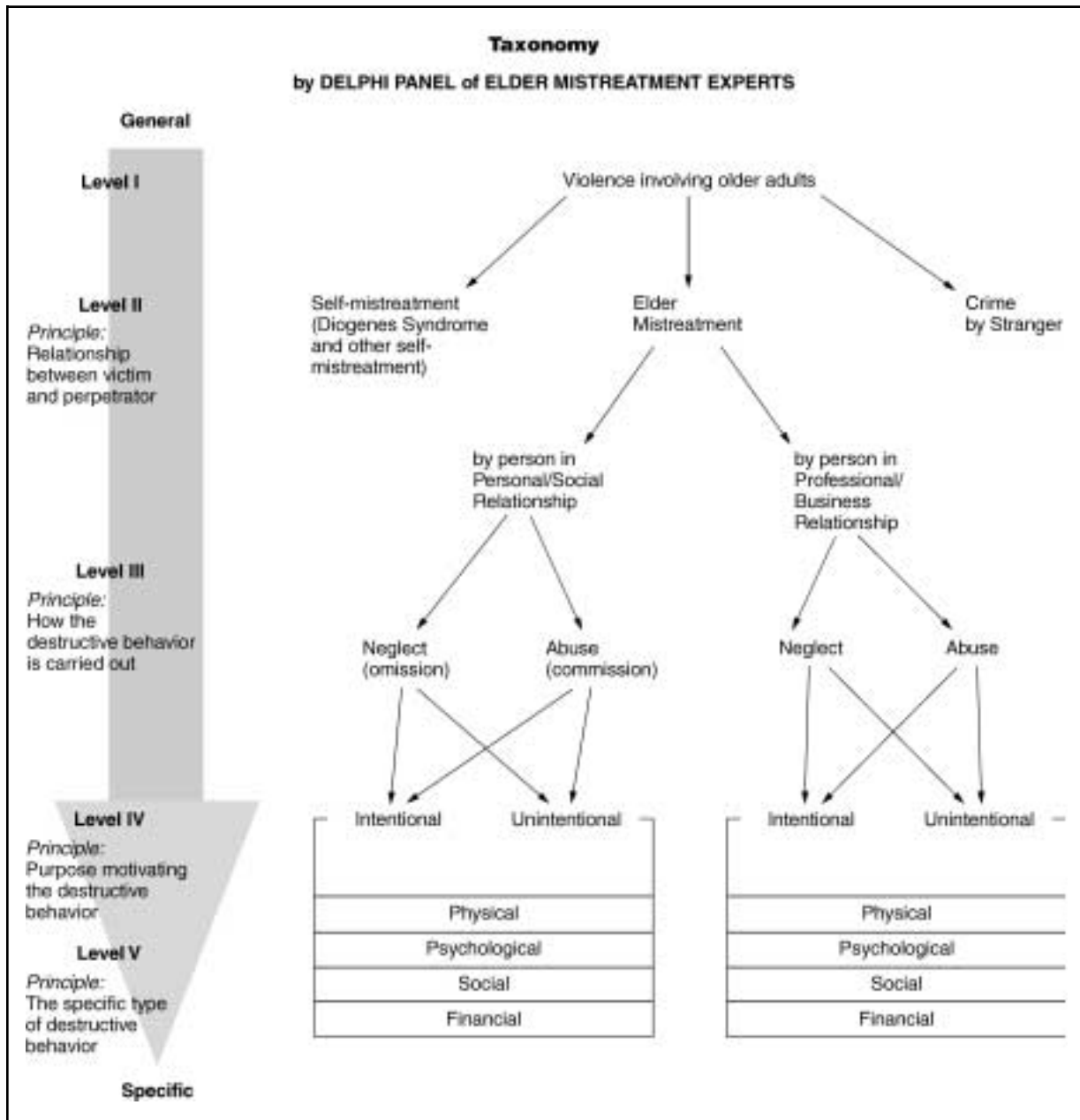
Most of the early research, which viewed elder neglect as a more benign subtype of elder abuse, examined the extent and nature of elder mistreatment among older adults living alone or with family members, friends, or other relatives and caretakers in the community. The prevailing view was that elder mistreatment was a domestic issue; it occurred within the family.

The early studies documented the existence of elder abuse and neglect, but did not provide clear or consistent information on the antecedents, causes, or consequences, or on the characteristics of the perpetrators or victims. For example, many of the early researchers identified functional disability, impairment, or dependence of the older adult as common correlates of both elder abuse and neglect (Douglass, Hickey, and Noel; O’Malley et al.; Steuer and Austin). More recent studies, which employed comparison of elder abuse and elder neglect cases, have found these characteristics are correlated with elder neglect but not with abuse (Phillips; Pillemer; Wolf). Some experts in the field believe that elder neglect is not a subtype of elder abuse (Fulmer and Gould; Hudson, 1986, 1991; Pedrick-Cornell and Gelles). Yet most of the research has included elder neglect as a subtype of abuse, confounding the findings for these two main forms of elder mistreatment. A few researchers have addressed both in the same study but have analyzed the results separately, providing evidence that elder abuse and neglect are distinct phenomena with differing risk factors and perpetrators.

Definitions and types of abuse and neglect

Since the definitions used by researchers and in state statutes vary, one instance of agreement is presented. In 1988, a three-round Delphi study was conducted with a nationwide panel of elder mistreatment experts to reach agreement on the types of elder abuse and neglect and on the definition of each type (Hudson, 1991). These researchers, clinicians, educators, and policy makers produced a taxonomy of elder mistreatment (Figure 1) and theoretical definitions of the eleven categories identified (Figure 2).

Figure 1



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Further, the panel made decisions about four previously debated issues. First, that elder mistreatment is not limited to domestic violence, but also includes mistreatment of older adults by persons in professional and business roles that connote trust, such as lawyers, doctors, nurses, and nurses' aides. Second, elder neglect and abuse are distinct forms of elder mistreat-

ment that would be most effectively studied separately. Third, intentional and unintentional forms of both elder abuse and neglect exist, and thus, intentionality is not an essential characteristic of either but, rather, an intervention issue. Last, dependence of the elder on the abuser or neglecter is not an essential characteristic of either form, although it is commonly

Figure 2
Theoretical Definitions

Level II	Elder Mis-treatment	Destructive behavior that is directed toward an older adult, occurs within the context of a relationship connoting trust and is of sufficient intensity and/or frequency to produce harmful physical, psychological, social and/or financial effects of unnecessary suffering, injury, pain, loss and/or violation of human rights and poorer quality of life for the older adult.
	Personal/Social Relationship	Persons in close personal relationships with an older adult connoting trust and some socially established behavioral norms, e.g., relatives by blood or marriage, friends, neighbors, any "significant other."
	Professional/Business Relationship	Persons in a formal relationship with an older adult that denotes trust and expected services, e.g., physicians, nurses, social workers, nursing aides, bankers, lawyers, nursing home staff, home health personnel, landlords, etc.
Level III	Elder Abuse	Aggressive or invasive behavior/action(s), or threats of same, inflicted on an older adult and resulting in harmful effects for the older adult.
	Elder Neglect	The failure of a responsible party(ies) to act so as to provide, or to provide what is prudently deemed adequate and reasonable assistance that is available and warranted to ensure that the older adult's basic physical, psychological, social, and financial needs are met, resulting in harmful effects for the older adult.
Level IV	Intentional	Abusive or neglectful behavior or acts that are carried out for the purpose of harming, deceiving, coercing or controlling the older adult so as to produce gain for the perpetrator (often labeled "active" abuse/neglect in the literature).
	Unintentional	Abusive or neglectful behavior or acts that are carried out, but NOT for the purpose of harming, deceiving, coercing or controlling the older adult, so as to produce gain for the perpetrator (often labeled "passive" abuse/neglect in the literature).
Level V	Physical	Behavior(s)/action(s) in which physical force(s) is used to inflict the abuse; or available and warranted physical assistance is not provided, resulting in neglect.
	Psychological	Behavior(s)/action(s) in which verbal force is used to inflict the abuse; or available and warranted psychological/emotional assistance/support is not provided, resulting in neglect.
	Social	Behavior(s)/action(s) that prevents the basic social needs of an older adult from being met; or failure to provide available and warranted means by which an older adult's basic social needs can be met.
	Financial	Theft or misuse of an older adult's funds or property; or failure to provide available and warranted means by which an older adult's basic material needs can be met.

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seen among victims of elder neglect (Hudson, 1991).

The five-level taxonomy produced was based on perpetrator behaviors. Level I, violence involving older adults, fits elder mistreatment into the scheme of violence phenomena while distinguishing it from violence involving persons of other ages. Level II, which is based on the relationship between perpetrator and victim, differentiates elder mistreatment from two closely related phenomena that involve harm to older adults—self-mistreatment and crime against elders by strangers. Level II also broadens the concept of elder mistreatment beyond domestic mistreatment to include professional mistreatment of elders. Level III is based on the manner

in which the harmful behavior is carried out, that is, by commission (abuse) or omission (neglect). Level IV, based on the purpose of the destructive behavior, promotes awareness that elder abuse and neglect occur intentionally and unintentionally, and conveys the experts' belief that detection can occur without the determination of intent or placement of blame. Level V focuses on the specific type of harmful behaviors involved in elder neglect and abuse. Categories include theoretically distinct behaviors that often are not mutually exclusive in actuality, so that a case may fit into more than one category. For example, the adult son who threatens and beats his mother while stealing her money fits into the categories of physical, psychological, and financial abuse; an adult daughter who has the needed resources

but allows her frail mother to unsafely live alone in an unmaintained home and to become isolated, malnourished, and injured from falling fits into the categories of physical, social, psychological, and financial neglect (Hudson, 1991). As the taxonomy levels proceed from general to specific, definitions of the more specific forms of neglect and abuse build from the general ones.

Elder neglect is the careless, indifferent, or malicious lack of attention by a designated or implied caregiver that results in harm from an elder's basic human needs not being met. This lack of action, or omission, makes neglect less tangible and more amorphous than elder abuse, because abuse is typically seen as an act of commission, or the misuse of power and/or the use of force, such as beating, shoving, confining, threatening, or belittling an elder. Because neglect is a lack of action, it is often not recognized until its cumulative effects are seen on the elder. Acts of neglect range in severity from intermittent inattention to an elder's daily fluid intake to total abandonment of an incapacitated elder. While the dynamics of elder neglect are different from those of abuse, the effects on the elder can be equally dire—premature death that is due to malnutrition, dehydration, untreated medical conditions, hypothermia, imposed immobility, and so on—rather than death from injuries due to assault. Although neglect is the most common form of elder mistreatment, surprisingly, it is also the form that has been given the least attention by researchers. Therefore, we know far less about elder neglect *per se* than we do about elder abuse. While both healthy and frail elders of various ages are abused, it is frail elders of advanced age—eighty years and older and dependent on others for their basic care—who are most at risk for neglect.

Incidence and prevalence

Determining the incidence and prevalence of elder abuse and neglect is very difficult, mainly because most cases are not known to anyone outside of the situation. Also, differing definitions of abuse and neglect, reporting agencies not keeping adequate information, and important differences in study methods have made reliable data elusive. While the actual incidence and prevalence of elder mistreatment in domestic and institutional settings is unknown and can only be estimated, all of the studies clearly indicate that most cases are unreported in spite of mandatory

reporting laws in all fifty states. Nevertheless, estimates from five studies provide some indications of the extent of elder neglect and abuse.

From interviews with community-dwelling elders in Boston, Pillemer and Finkelhor estimated that yearly in Massachusetts some 3.2 percent of older adults are physically or psychologically abused or neglected by their caregivers (financial and social abuse and self-neglect were not included). Yet only one in every fourteen of these cases came to professional attention in spite of the state's mandatory reporting law. In their survey of nurses and nurses' aides from area nursing homes, Pillemer and Moore found that 36 percent of the staff had seen at least one incident of a resident being physically abused in the previous year, while 81 percent had seen psychological abuse. Most of this mistreatment did not get reported to authorities. Another study, in which older adults were interviewed, found that 7.5 percent of the respondents reported that they had been physically, psychologically, socially, or financially abused since turning sixty-five years of age (Hudson and Carlson, 1998, 1999). If neglect or self-neglect were added, the prevalence rate would be higher.

Tatara conducted a survey to estimate the national incidence of domestic elder mistreatment. Based on data from only twenty-nine states, he estimated that 735,000 elders were victims of abuse or neglect during 1991, while another 842,000 were victims of self-neglect. He also found that only 14.4 percent of these cases of mistreatment were reported to protective services agencies. The National Elder Abuse Incidence Study (Takamura and Golden) included reported and unreported cases of abuse, neglect, and self-neglect. The findings suggested that some 551,011 adults over the age of sixty living in domestic settings (institutional mistreatment was not included) were abused or neglected during 1996, and for every reported case of mistreatment, approximately five went unreported. Neglect was the most common form of mistreatment found, followed by psychological abuse, financial abuse, and physical abuse. As compared to their composition in the older adult population, women were disproportionately represented in all the abuse categories, and men were disproportionately found in the abandoned group. The neglect cases showed a more proportional distribution between men (40 percent) and women (60 percent).

Victim and perpetrator characteristics

Some studies have addressed specific types of elder abuse and/or neglect to identify the characteristics associated with each. The findings from these studies produced three distinct patterns of victim and perpetrator characteristics. Victims of both physical and psychological elder abuse were found to be both men and women who were young-old (sixty-five to seventy-four years), married, more independent in activities of daily living but in poor emotional health with low morale, in troubled marriages, living with others, lacking confidants, and socially isolated. Their perpetrators were often spouses who had histories of mental illness or problems, had abused alcohol, had a recent decline in mental and/or physical health, were dependent on and lived with the victim, and had experienced recent stress. The perpetrators' characteristics and the quality of the abuser-victim relationship were more related to the abuse than the victims' characteristics, which left victims with few resources for dealing with the abuse.

Participants in material abuse, or exploitation, had a different set of characteristics. Victims tended to be unmarried (widowed, divorced, or never married), older women or men who lived alone and had problems with money management and transportation. They lacked adequate social supports or confidants. Health problems, poor morale, and/or depression limited their activities. Their perpetrators tended to be younger, distant relatives or nonrelatives who abused alcohol and had physical or emotional problems. They did not live with the victims but were financially dependent on them. In material abuse, the victims' characteristics seemed to make them vulnerable to perpetrators who could not function independently (Anetzberger, Korbin, and Austin; Pillemer; Podnieks; Wolf, Godkin, and Pillemer).

In contrast to elder abuse, in which perpetrator characteristics seem to be most relevant, the victims' characteristics seem to be most relevant to elder neglect. Based on studies that compared abuse with neglect, neglect victims were more often old-old (eighty years and older), widowed, disabled women who were dependent on caregivers due to poor health and physical and/or mental impairment. Often they lived with the person who neglected them and had few other people in their social networks. The male and female perpetrators were family members and un-

related caregivers who had experienced losses in their own support system, and viewed the elder as the source of stress (Podnieks; Wolf, Godkin, and Pillemer).

Prevention and intervention

Research has yet to adequately address these aspects of elder mistreatment. One of the most established programs serving mistreated elders is the Elder Abuse Project sponsored by the Victim Services Agency at Mt. Sinai Hospital in New York directed by Risa Breckman (Breckman and Adelman). Breckman is also the codirector of the Elder Abuse Training and Resources Center, which provides training, technical assistance, and case consultation services to organizations throughout the country. Rosalie Wolf and Karl Pillemer present four of the best practice models—a multidisciplinary case conference team from San Francisco, a volunteer advocacy program from Madison, Wisconsin, a victim support group from New York City, and a master's degree adult protective services track in social work in Hawaii. They also address some of the common problems faced by community agencies that deal with elder mistreatment cases—the fragmented human services system, the resistance and reluctance of victims to accept services, and the shortage of trained personnel.

Effective intervention in elder mistreatment cases is often difficult to accomplish. First and foremost, since many mistreated elders are competent adults they have the right to refuse assistance even when it is obviously needed. Many of them deny that abuse or neglect is occurring or refuse any assistance offered, often due to embarrassment or fear of retaliation. Only when an older adult is ruled mentally incompetent by a court and a guardian is appointed can intervention be instigated without the elder's consent. Second, in many communities the resources needed for intervention are nonexistent or very limited. Sometimes the only option available is to remove the elder from his or her home. Yet both abuse and neglect also occur in rest and nursing homes. So for some elders the treatment is worse than the original problem. Third, the care of mistreated elders typically requires a multidisciplinary team of health care and human services providers who are well trained regarding the needs of older adults and the needs of abused or neglected elders, and who can address their medical, social, psychological, housing, and legal

needs. Fourth, since very little research has been done on elder mistreatment intervention, including which strategies produce the most effective and efficient outcomes, practitioners have little evidence-based information to guide them in caring for these elders. Last, funding has been very limited for instituting or maintaining new initiatives for managing mistreatment cases.

Theoretically speaking, the prevention of elder abuse and neglect will require that ageism be eliminated in our society, and that we restore respect for and honor to our older adults. In addition, it will require that we educate everyone about aging, instill the value of people over material objects, and establish the resources needed to provide quality care for our aged members. Empirically speaking we do not yet know how to effectively prevent or intervene in elder abuse or neglect cases. Very little research has been done on these aspects of elder mistreatment, and there is very little outcome or programmatic evaluation data. Therefore, clinical judgment typically guides prevention and intervention. Until sound research addresses these important aspects of elder mistreatment, this will continue to be the case.

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See also AGEISM; CRIMINAL VICTIMIZATION.

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ELDER MISTREATMENT

See ELDER ABUSE AND NEGLECT

ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) involves the use of a brief electrical current to produce a seizure in the brain. Many studies have shown ECT to be an effective treatment for severe psychiatric disorders, particularly major depressive disorders. ECT is believed to work by regulating neurotransmitter systems in the brain, the same way other somatic (physical) psychiatric treatments (including medications) work.

Historical origins

ECT was discovered in Europe in the first part of the twentieth century. In 1934, a Hungarian psychiatrist, Ladislav von Meduna reported on the successful use of a chemical product, camphor, to induce epileptic seizures (convulsions)

in a series of patients with schizophrenia. This form of convulsive therapy was found to be efficacious but extremely unpleasant. Four years later, the Italians Ugo Cerletti and Luigi Bini used electricity to induce seizures.

ECT was first used in the United States in 1940, and within a few years it became widely used. Following the development of effective psychiatric medications in the 1950s, the use of ECT and other somatic psychiatric treatments, such as psychosurgery, decreased markedly. However, a number of studies have shown that some patients who do not respond to medications can be treated successfully with ECT. As of 2000, it was estimated that about 100,000 American patients with severe psychiatric disorders were treated annually with ECT.

Indications

Over the years, ECT equipment and techniques have been perfected, and recent scientific studies have confirmed that ECT is an extremely safe and effective treatment. However, in large part due to its negative and sensational portrayal in the media, ECT remains a controversial treatment. As a result, it is usually used when pharmacotherapy (drug treatment) has been ineffective or poorly tolerated. Nevertheless, ECT can be used as a first-line treatment when a rapid response is needed—for instance to treat an actively suicidal patient; a depressed patient refusing fluids, food, or medications; a patient that presents with a recurrence of a disorder that has responded to ECT but not to medications in the past; or a patient that requests to be treated with ECT rather than medications.

ECT is mostly used to treat severe depressive episodes associated with recurrent depression, bipolar disorder (manic-depressive illness), or due to general medical conditions. ECT can also be used to treat other conditions when they have not responded to pharmacotherapy or when rapid treatment is needed; such conditions include manic episodes; schizophrenia and other psychotic disorders; catatonic states of any cause; or prominent depressive symptoms associated with Alzheimer's disease and other dementias. In rare instances, ECT has been used to treat other psychiatric disorders and some physical disorders (e.g., treatment-resistant Parkinson's disease). Older patients with severe depression often present with psychosis, suicidal thoughts, or refusal of food and fluid requiring rapid treat-