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The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment

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Abstract

Elder mistreatment is experienced by 10% of older adults and is much more common among older adults with dementia. It is associated with increased rates of psychological distress, hospitalization and death and, in the US, costs billions of dollars each year. Though elder mistreatment is relatively common and costly, it is estimated that less than 10% of instances of elder mistreatment are reported. Given these data, there is a great need for research on interventions to mitigate elder mistreatment, and a practical model or framework to use in approaching such interventions. While many theories have been proposed, adapted and applied to understand elder mistreatment, there has not been a simple, coherent framework of known risk factors of the victim, perpetrator, and environment that applies to all types of abuse. In this paper we present a new model to examine the multidimensional and complex relationships between risk factors. This model is informed by theories of elder mistreatment, research on risk factors for elder mistreatment and 10 years of experience of faculty and staff at an Elder Abuse Forensics Center who have investigated more than 1000 cases of elder mistreatment. We hope this model, the Abuse Intervention Model (AIM), will be used to study and intervene in elder mistreatment.

Keywords

elder mistreatment; model; elder abuse

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RATIONALE FOR A MODEL TO ADDRESS ELDER MISTREATMENT

As defined by the Centers for Disease Control and Prevention,¹ elder abuse (mistreatment) is an intentional act or failure to act by a caregiver or another person in a trust relationship involving an expectation of trust that causes or creates a risk of harm to an older adult. Mistreatment may be in the domains of physical, sexual, emotional/psychological, or financial abuse/exploitation, and neglect. Elder mistreatment is associated with increased rates of psychological distress, hospitalization and death^{2, 3, 4} and, in the US, costs billions of dollars each year.⁵ One in ten US adults aged 60 years and older experience abuse each year⁶ and nearly one in two adults with dementia experience abuse by others.^{7, 8} Despite these rates, elder mistreatment is under reported. Between one in fourteen and one in forty-four cases of elder mistreatment come to the attention of authorities.⁹

Given these data, there is a great need for research on interventions to mitigate elder mistreatment, and a practical model or framework to use in approaching such interventions. While many theories have been proposed, adapted and applied to understand elder mistreatment, there is no simple, coherent framework of known risk factors of the victim, perpetrator, and environment that applies to all types of abuse.¹⁰ In this paper we present a new model to examine the multidimensional and complex relationships between risk factors informed by theories of elder mistreatment, research on risk factors for elder mistreatment and 10 years of experience among personnel at the Orange County, California Elder Abuse Forensics Center who have investigated more than 1000 cases of elder mistreatment. We hope this model, the Abuse Intervention Model (AIM), will be used to identify risk factors for elder mistreatment for individual cases and enable a plan to be developed to prevent or mitigate elder mistreatment.

Theories informing AIM

A prior review by Burnight and Mosqueda¹¹ identified interpersonal,^{12, 13, 14, 15} sociocultural¹⁶ and multisystem^{17, 18} theories as the predominant theories explaining elder mistreatment.

Interpersonal theories

Caregiver stress theory posits that elder mistreatment occurs when an adult caring for a vulnerable older adult is not able to manage the caregiving responsibilities and becomes abusive.¹² *Social exchange theory* explains interactions between people as a process of negotiated exchanges.¹³ Social exchanges may include material goods like money, housing and non-material goods like approval and prestige. Those who receive goods from another may feel pressure to return a similar amount of goods and this may cause stress and increase the risk of mistreatment. *Dyadic discord theory*¹⁴ asserts that relationship discord can lead to mistreatment and results from a combination of contextual factors (e.g., a history of family violence and lack of satisfaction in a relationship). *Social learning theory*¹⁵ posits that violence is a learned behavior. Elder abuse may result from the abusive person having learned to use violence in an earlier context to resolve conflicts or obtain a desired outcome.

Sociocultural theory

Power and Control Theory posits that the abuser uses coercive tactics to gain and maintain power and control in the relationship.¹⁶

Multisystem theories

Ecological theory may be used to organize potential causes of mistreatment into groups.¹⁷ Using this framework allows one to examine elder mistreatment by considering the broader system (context) in which it occurs. These systems are at the level of the individual or vulnerable elder (microsystem), family/friend/caregiver/trusted other level (mesosystem), community level such as the family member's workplace or senior center (exosystem), and societal norm/policy level such as a particular culture (macrosystem). An adaptation of the ecological framework to explain elder mistreatment, focused on physical abuse, is the *Ecological Bi-Focal Model*.¹⁸ It is bifocal in that it examines the characteristics of the older adult, the adult child and the characteristics of their relationship. Characteristics of the older adult (physical/psychological health and social isolation) and characteristics of the adult child (emotional/psychological problems, alcohol/substance abuse, and financial problems) are mediated by the quality of the parent/child relationship.

These theories range from explaining elder mistreatment as being caused by characteristics of an individual (vulnerable elder or trusted other) to characteristics of the relationship between the vulnerable elder and trusted other to characteristics of the vulnerable elder, the trusted other and their relationship. These theories have informed the AIM we are presenting here to identify and address risk factors from the three domains of I) vulnerable older adult, II) trusted other and III) context.

Risk Factors for Elder Mistreatment

In the AIM, we include risk factors within each of the three domains. These were identified from a combination of the literature on elder mistreatment/family violence and the experience of those working in an Elder Abuse Forensics Center. Some risk factors are not modifiable (e.g., diagnosis of dementia) but many are (e.g., aggression as a symptom of dementia). In the next section we describe potentially modifiable risk factors in each of the three domains: 1) vulnerable older adult, II) trusted other and III) context. (See Figure 1)

Domain I: Vulnerable older adult

Vulnerability, defined as financial, physical or emotional dependence on others or impaired capacity for self-care or self-protection¹⁹, places older adults at risk of mistreatment. The personal characteristics that increase older adults' vulnerability to mistreatment include dependence on others for care and being perceived as difficult to care for or to be around. Major categories or sub domains of such risk factors are: 1) Impaired physical function: Impairments in physical function (e.g., osteoarthritis with mobility limitation, stroke with paralysis) can reduce one's ability to perform basic and instrumental activities of daily living (ADLs and IADLs)^{20, 21}; 2) Impaired cognition: Impairments in cognition (e.g., dementia, mild cognitive impairment, intellectual disability) can limit performance of ADLs and IADLs, and cause impairment in executive function. Such impairments may predispose the

elder to behaviors that make caregiving difficult and result in poor judgment and lack of insight that enables financial exploitation to occur.^{22, 23, 24} 3) Emotional distress and/or mental illness: Emotional distress and/or mental illness (e.g., depression or personality traits such as narcissism) may make caregiving difficult.²⁵ Such impairments can also lead to emotional dependence that others may resent or exploit.

Domain II: Trusted other

The term “trusted other” includes a variety of people including family members, neighbors, friends, paid caregivers, other household employees, financial advisors, and other advisors. Major categories or sub domains of “trusted other” risk factors are: 1) Dependency: Dependence on the vulnerable older adult, particularly financial dependence that may require the trusted other to maintain an unwanted relationship with the older adult. Emotional dependence on the older adult may result in conflicted relationships that foster hostility and resentment; 2) Emotional distress and/or mental illness: Mood or substance use disorders or pathologic personality traits such as hostility may limit the capacity of the person to be a good and reliable caregiver.^{26, 27} Further, caregivers who are experiencing major stress may be prone to behave in an abusive manner. 3) Impaired physical function: Impairments in physical function (e.g., osteoarthritis with mobility limitation) can reduce one’s ability to provide appropriate, needed care.

Domain III: Context

The context in which an older adult and trusted other interact plays an important role in either mitigating or exacerbating elder mistreatment. Major aspects of context include 1) Social isolation: Social isolation may exacerbate risk for elder mistreatment. For example, if the vulnerable elder and trusted other are not connected to social supports, if there no one else to help when needed, if they are not observed by others who can offer help, and if the trusted other is purposely keeping the vulnerable older adult isolated.^{8, 20, 21, 28, 29} 2) Low-quality relationship: Often the relationship between a vulnerable elder and a trusted other began before caregiving was needed. A good quality relationship may protect against elder mistreatment while a poor quality relationship may promote elder mistreatment³⁰ 3) Cultural norms (i.e., behavioral patterns that are typical of specific groups): Different cultures or groups may have differing views on what constitutes elder mistreatment. Some groups may view particular illness, such as Alzheimer’s disease, as shameful or embarrassing and may wish to isolate the vulnerable elder and/or caregiver, thus increasing risk for elder mistreatment. Some groups may view self-reliance as a norm and so inhibit caregivers from seeking help.^{31, 32} Some groups may view self-reliance as a norm and so inhibit caregivers from seeking help. Further, typical behavior in one age cohort may be significantly different than other cohorts and increase risk. For example, some grew up in an era where a paternalistic role was expected for a physician and therefore a person from that cohort may be less likely to introduce a taboo topic such as the abuse they are suffering at the hands of a spouse.

We will present two hypothetical cases to illustrate how one can use the AIM to identify risk factors within each domain that are relevant to an individual situation.

CASE 1

Mrs. S brings her 86 year old husband with Alzheimer's disease to his primary care physician for an appointment. Mr. S. has moderately advanced Alzheimer's disease with limitations in his ADLs including bathing, toileting and dressing. He is resistant to allowing others to help. His last visit was 6 months ago and his physician notes a significant cognitive decline. He has unclean clothes and he smells of urine. The physician refers the patient to a social worker affiliated with his office because he is concerned the patient's wife is not able to care for him.

The social worker obtains the following information. Mrs. S. is the patient's primary caregiver. This is a second marriage for the patient; they have been married for 30 years and have no children. Mrs. S. has osteoarthritis that limits her ability to do IADLs and to assist her husband with his ADLs. She finds it stressful to assist her husband due both to her physical limitations and his resistance to care. Mr. and Mrs. S. have good financial resources but Mr. S. used to manage them and Mrs. S. is not comfortable taking over. She was born in 1930 and in that era, the norm was that the husband took care of the finances. In addition, Mr. S. has three adult children from his first marriage. The relationship between Mrs. S. and the adult children is strained. She is concerned that they would be critical of decisions she made regarding his care needs. She has discontinued many of her own activities over the past several months to provide care for her husband and feels isolated. Figure 2 illustrates the risk factors for this case using the AIM.

Intervening to address risk factors identified using the AIM

Using the AIM to understand this situation lead to the following interventions: The social worker referred Mrs. S. to: 1) a psychotherapist to help her manage stress and perceived burden. She hired an in-home caregiver and developed a better relationship with her step children. 2) the Alzheimer's Association Savvy Caregiver Course to learn strategies to assist her husband with his ADLs that would result in less resistance to care and thus reduce conflict. Because she had to provide direct caregiving less frequently once the in home care giver was in place, she was also able to re-establish former friendships and engage in activities to help improve her own physical health. 3) the Legal Aid Society to help her develop a long-term financial plan to provide for both her and her husband's needs. As a result of this referral, Mrs. S. and her husband's adult children met with the attorney to develop a health care directive and a long term financial plan that anticipated the costs of ongoing caregiving needs.

CASE 2

Mr. P is an 82-year-old who has been depressed following his wife's death three years ago. He has progressive vision loss from macular degeneration limiting his ability to prepare meals, take medications and drive. One year ago, Mr. P hired an in-home caregiver to assist him with his IADLs. The caregiver initially worked three days per week but six months ago increased her hours and moved into Mr. P's home. Mr. P. says that she is "a life saver".

One month ago, Mr. P's adult daughter discovered that Mr. P allows the caregiver to open his mail and has him sign documents to manage his banking so that he is "not a burden on his daughter". The daughter called Mr. P's physician as she is concerned her father is being victimized by his in-home caregiver. The physician referred her to Adult Protective Services (APS).

The daughter reported to the APS worker that the caregiver discouraged her from visiting her father for several months. Ultimately the daughter made an unannounced visit and insisted on seeing her father. She asked the caregiver to leave the home while she visited, and found paperwork on Mr. P's desk indicating he had signed documents giving his home to the caregiver. Figure 3 illustrates the risk factors for this case using the AIM.

Intervening to address risk factors identified using the AIM

Using the AIM to understand this situation lead to the following interventions: 1) APS staff made a police report. 2) Police investigation lead to successful prosecution and rescinding of the grant deed gifting the home to the caregiver. 3) The daughter became more involved in her father's care, and hired a caregiver through an agency. 4) Ultimately, Mr. P decided to move to an assisted living facility where his needs could be met in a more social environment. In this environment his depression improved.

Implications for the AIM to reduce elder mistreatment

The two cases illustrate how the AIM may be used to provide clinicians and other professionals such as social workers, APS and Forensics center staff with a framework to assess risk factors for elder mistreatment from the perspective of the vulnerable older adult, the trusted other and the context in which they interact. Identifying risk factors can help professionals further investigate and address the salient and modifiable risk factors to mitigate mistreatment. The AIM must be studied to ascertain if it can successfully serve as a guide to assessment and intervention of elder mistreatment. One study examining its utility for dyads of demented older adults and their caregivers is underway, (HHS-2012-ACL-EA-1214) but more research should be undertaken to evaluate its potential to be used to identify and intervene to mitigate elder mistreatment of all types. For example, in using the AIM, particular risk profiles may be seen frequently (e.g., a) demented older adult who is resistant to care, b) adult child caregiver who is financially dependent on the older adult and depressed c) context of the older adult and the adult child caregiver being socially isolated). When high frequency risk profiles are identified, a "toolkit" of interventions specific to that profile could be developed and deployed. Further, if the AIM is useful in identifying and addressing elder mistreatment, it may also help guide public policy and allocation of resources to prevent and address elder mistreatment.

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Figure 1.
Abuse Intervention Model (AIM)

Figure 2.
Case 1

Figure 3.
Case 2