Elder abuse is a problem that occurs across all settings and is encountered by all health care providers and others not in the health care field. Elder abuse is “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (World Health Organization, n.d., para. 1). Elder abuse has many forms, such as abandonment, emotional or psychological abuse, financial or material exploitation, neglect, physical abuse, and sexual abuse (Daly & Jogerst, 2001, 2006). In addition, resident-to-resident abuse can occur in institutional settings.

In institutional settings, elder abuse can take on a different meaning. According to Wierucka and Goodridge (1996):

The collective nature of institutions means there is greater potential for abuse/neglect to occur as there are more people and more interactions than in community settings. The nature of the interactions may create very strong tensions among administrators, staff, and residents. The client and his/her family are more physically and psychologically vulnerable than in other settings. (p. 88)

Estimates of elder abuse prevalence are available from a variety of sources, such as adult protective service agencies, probability samples of older adults in communities, health care personnel working with older individuals, and medical record review. Nine epidemiological community-based prevalence studies have been conducted (Acierno et al., 2010; Chokkanathan & Lee, 2005; Comijs, Pot, Smit, Bouter, & Jonker, 1998; Keskinoglu et al., 2007; Kivelä, Köngäs-Savioaro, Kesti, Pahkala, & Ijas, 1992; Ogg & Bennett, 1992; Oh, Kim, Martins, & Kim, 2006; Pillemer & Finkelhor, 1988; Podnieks, 1992). From the most recent prevalence study of individuals 60 and older, 1 in 10 respondents reported emotional, physical, or sexual abuse, or potential neglect in the past year.

**PURPOSE**

The purpose of this evidence-based practice guideline is to facilitate health care professionals’ assessment of older adults in domestic and institutional settings who are at risk for elder abuse, and to recommend interventions to reduce the incidence of mistreatment. The guideline is intended for frontline staff (e.g., RNs, licensed practical nurses, nursing assistants) who provide care for older adults and their families in domestic or institutional settings. This protocol helps nursing caregivers assess older adults for potential or actual abuse, develop a care plan, and implement strategies for prevention of elder abuse. It is also intended for managers and administrators who develop policy and procedures and conduct investigations of abuse. The full text of *Elder Abuse Prevention* (Daly, 2010) is available for purchase from The University of Iowa Hartford Center of Geriatric Nursing Excellence at http://www.
DEFINITIONS OF KEY TERMS

The following definitions of types of elder abuse are from the National Center on Elder Abuse (NCEA, 2011):

- **Abandonment** is the desertion of an older person by an individual who has assumed responsibility for providing care for the older adult, or by a person with physical custody.
- **Emotional or psychological abuse** is the infliction of anguish, pain, or distress through verbal or nonverbal acts.
- **Physical or material exploitation** is the illegal or improper use of an older adult’s funds, property, or assets.
- **Neglect** is the refusal or failure to fulfill any part of a person’s obligations or duties to an older adult.
- **Physical abuse** is the use of physical force that may result in bodily injury, physical pain, or impairment.
- **Sexual abuse** is nonconsensual sexual contact of any kind with an older adult.

In addition, according to Rosen et al. (2008), resident-to-resident aggression is “negative and aggressive physical, sexual, or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress to the recipient” (p. 1398).

INDIVIDUALS AT RISK FOR ELDER ABUSE

Various factors are associated with individuals who are victims of abuse or at risk for abuse. Those who are older (Cohen, 2008; Lachs, Berkman, Fulmer, & Horwitz, 1994; Lachs, Williams, O’Brien, Hurst, & Horwitz, 1996; Pillemer & Finkelhor, 1988), married (Pillemer & Finkelhor, 1988; Podnieks, 1992), have a low educational level and low income level (Baker et al., 2009; Cohen, 2008), and are non-White are at higher risk for elder abuse (Lachs et al., 1994; Lachs, Williams, O’Brien, Hurst, & Horwitz, 1997; Shugarman, Fries, Wolf, & Morris, 2003).

Older adults in a shared living situation are more likely at risk for abuse than those living alone (Burgess, Brown, Bell, Ledray & Poarch, 2005; Lachs et al., 1997; Pillemer & Finkelhor, 1988; Pillemer & Suitor, 1992). Risk of abuse is also evident for adults who are socially isolated, have poor social networks, or have low social support (Acierno et al., 2010; Lachs et al., 1996). In addition, alcohol abuse (Anetzerberger, Korbin, & Austin, 1994) and exposure to a previous traumatic event (Acierno et al., 2010) place older adults at risk for abuse.

CONSEQUENCES OF ELDER ABUSE

Elder abuse is associated with a range of adverse health outcomes. There is evidence of greater mortality risk (Baker et al., 2009; Lachs, Williams, O’Brien, Pillemer, & Charlson, 1998); higher dependence in performance of activities of daily living (Cohen, 2008); and increased dementia, delusions, and depression (Cooper et al., 2006; Cooper, Manela, Katona, & Livingston, 2008; Coyne, Reichman, & Berbig, 1993; Dyer, Pavlik, Murphy, & Hyman, 2000; Pillemer & Suitor, 1992). Other findings indicate that older women who experience abuse are likely to consult practitioners with conditions such as physical injuries, gynecological issues, gastrointestinal disorders, fatigue, headache, myalgias, depression, and anxiety (Mouton & Espino, 1999).

ASSESSMENT TOOLS AND FORMS

Several tools are available to assess adults at risk for abuse or actual victims of abuse. The tools may be short screening questions or in-depth assessments depending on the individual being assessed and practice setting. The following tools are available in the complete guideline (Daly, 2010):

- **Actual Abuse Tool** (Bass, Anetzerberger, Eajaz, & Nagpaul, 2001).
- **Elder Abuse Suspicion Index®** (Yaffe, Wolfson, Lithwick, & Weiss, 2008).
- **Elder Assessment Instruments** (Fulmer, 2003; Fulmer & Cahill, 1984; Fulmer & Wetle, 1986).
- **Health, Attitudes Toward Aging, Living Arrangements, and Nursing,** uiowa.edu/Hartford/nurse/ebp.htm.
Finances (HALF) Assessment (Ferguson & Beck, 1983).
- Index of Spouse Abuse (Hudson & McIntosh, 1981).
- Indicators of Abuse Screen (Reis & Nahmiash, 1998).
- Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975).
- Partner Violence Screen (Feldhaus et al., 1997).
- Risk of Abuse Tool (Bass et al., 2001).
- Screen for Various Types of Abuse or Neglect (American Medical Association, 1992).
- Suspected Abuse Tool (Bass et al., 2001).
- Two-Question Abuse Screen (McFarlane, Greenberg, Weltge, & Watson, 1995).
- Vulnerability to Abuse Screening Scale (Schofield, Reynolds, Mishra, Powers, & Dobson, 2002).

**DESCRIPTION OF THE PRACTICE**

Prevention of elder abuse requires the involvement of multiple sectors of society. Education and dissemination of information are vital for health care professionals and for the general public. Interventions for prevention of elder abuse have been suggested but have not been tested. According to the National Research Council (2003):

No efforts have yet been made to develop, implement, and evaluate interventions based on scientifically grounded hypotheses about the causes of elder mistreatment, and no systematic research has been conducted to measure and evaluate the effects of existing interventions. (p. 121)

Unfortunately, only 14 elder abuse intervention studies have been conducted, with the majority focused on education interventions for caregivers (Daly, Merchant, & Jogerst, in press; Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009). Other interventions attempted were support groups for caregivers, which did not alleviate stress (Hisieh, Wang, Yen, & Liu, 2009), and daily money management for the older adults to hinder financial exploitation, which did not lessen financial exploitation (Wilber, 1991). Appropriate interventions for preventing elder abuse could include legislation, education, respite, social support, batterer interventions, and money management programs.

**Legislation**

Limited research has been conducted on adult protective services-related legislation and its relationship to elder abuse reports, investigations, and substantiations. In a landmark study, Jogerst, Daly, Brinig, et al. (2003) reviewed all 50 states and the District of Columbia’s adult protective service-related statutes and regulations to evaluate the impact of state adult protective service legislation on the rates of investigated and substantiated domestic elder abuse. The following is a list of significant findings:

- States that require public education regarding elder abuse correlated with higher abuse report rates, suggesting that heightened public awareness increases reporting of elder abuse.
- States that require mandatory reporters had a significantly higher investigation rate.
- The substance of how the mandatory reporting requirement was written in the statute was not important (i.e., listing all the mandatory reporters or just saying “any person”).
- Thirty-three states had a provision for penalties for failure to report abuse, which was significantly associated with higher investigation rates.
- Investigation rates were almost identical between states with or without a specific definition/criterion of adult dependence or vulnerability.

- The higher the number of abuse definitions in the regulations, the higher the substantiation rates and ratios of substantiation/investigations, as some states have one generic definition covering multiple types of abuse, and other states define each type of abuse (i.e., abandonment, emotional abuse, exploitation, neglect, physical abuse, sexual abuse).
- Caseworkers who only investigated elder abuse reports had a higher substantiation ratio than caseworkers assigned to both child and elder abuse work.
- A state’s administrative decision to track reports of abuse led to significantly higher investigation and substantiation rates as well as substantiation ratios.
- A higher proportion of total population categorized as “elderly” was associated with lower substantiation rates.

Research pertinent to mandatory reporters and the reporting of elder mistreatment is recommended (National Research Council, 2003). Forty-four states and the District of Columbia have laws providing that individuals who assume the care or custody of older people are considered mandatory reporters, and 38 statutes specify a penalty for mandatory reporters who do not report abuse or suspected abuse. Higher abuse investigations rates are associated with mandatory reporting requirements in the law (Daly, Jogerst, Brinig, & Dawson, 2003).

**Education**

Iowa is the only state that requires education for mandatory reporters. A person required to report allegations of dependent adult abuse must complete 2 hours of training within 6 months of initial employment and every 5 years thereafter (Iowa State Code, 2001). Comparing the investigation and substantiation rates for elder abuse allegations before and after July 1988, when Iowa statute was revised to ensure training of manda-
tory reporters, elder abuse investigation and substantiation rates did not change (Jogerst, Daly, Dawson, Brinig, & Schmuch, 2003).

It is evident that legislation and public policy have an impact on elder abuse rates, but other interventions, specific to the type of abuse, are also beneficial. Approximately eight educational interventions focusing on caregivers have demonstrated utility in preventing or reducing elder abuse (Désy & Prohaska, 2008; Goodridge, Johnston, & Thomson, 1997; Hsieh et al., 2009; Pillemer & Hudson, 1993; Richardson, Kitchen, & Livingston, 2002, 2004; Uva & Gutman, 1996; Vinton, 1993). Educational interventions range from 1 to 8 hours and are taught by many different methods, such as one-on-one instruction, in a classroom or at a conference, or with group support. Improvements after educational interventions were noted by increased knowledge (Désy & Prohaska, 2008), use of assessment tools (Désy & Prohaska, 2008), improved job performance (Goodridge et al., 1997), and declines in reports of abusive actions of staff (Pillemer & Hudson, 1993).

Pillemer and Hudson (1993) developed and implemented a model abuse prevention curriculum for nursing assistants employed in nursing facilities. The eight-module curriculum included video, lecture, problem solving, role-playing, and group support (Hudson, 1992). Following the intervention, the number of conflicts with residents declined and a reduction in resident aggression was reported. Another educational intervention consisting of a video, booklet, and interactive workshop was conducted with nursing assistants in nursing facilities in Hawaii. The pre-/posttest design indicated improved job satisfaction (Braun, Suzuki, Cusick, & Howard-Carhart, 1997).

Reis and Nahmiash (1995) implemented an intervention model to combat abuse/neglect of older adults living in the community. The model included a screening tool package, teams to design and execute intervention strategies, advice on problems, volunteer buddies, a victim’s empowerment group, and education. However, no outcomes were tested to determine the impact of the intervention model.

Other interventions that have been suggested in the literature include home visitation programs, respite for caregivers, development of pro-social skills for caregivers, intensive multicomponent support services for caregivers, counseling for caregivers, and shelter stays for care recipients (Nicoll, Ashworth, McNally, & Newman, 2002; Rhodes & Levinson, 2003; Townsend & Kosloski, 2002; Warthen & MacMillan, 2003).

Respite

Respite is a potential intervention to prevent elder abuse. Three types of respite care are available: adult day care, in home, and institutional (Townsend & Kosloski, 2002). Among families and service providers, respite services are desired and needed by individuals caring for those who are dependent. According to Nicoll et al. (2002), “respite is one way that the strain of caring may be relieved” (p. 479). This relief might reduce the caregiver’s level of stress and burden, which could enhance the quality of interactions between the caregiver and dependent person, which may in turn alleviate some abuse.

Ten in-depth qualitative interviews of caregivers identified the need to support the caregiver’s role (Lane, McKenna, Ryan, & Fleming, 2003). The stress of caring for someone 24 hours per day affects the caregiver’s psychological well-being. In-home respite was suggested as a means to relieve the burden without causing additional problems for the dependent person related to relocation. Family support was another suggestion to relieve caregiver burden (Lane et al., 2003). Another study identified factors related to client satisfaction and found that those caregivers who were able to dress and transport the dependent person to adult day care services were significantly more satisfied than those caregivers who were unable to do so (Montgomery, Marquis, Schaefer, & Kosloski, 2002; Townsend & Kosloski, 2002).

During a pilot of a weekend respite program, it was found that caregivers need to be reassured their loved ones are safe in a respite program and that both the caregiver and dependent person benefit from the experience (Perry & Bontinen, 2001). In addition, social support is an important factor in a caregiver’s satisfaction with respite care (Nicoll et al., 2002). Polarity therapy, a touch therapy that uses gentle pressure on energy points and biofields to help clients achieve physiological relaxation, was tested as an alternative to respite (Korn et al., 2009). Caregiver stress, depression, vitality, and general health improved in the polarity therapy group when compared to the enhanced respite group.

A meta-analysis of respite intervention studies was conducted to determine its effect on caregivers (McNally, Ben-Shlomo, & Newman, 1999). Twenty-nine studies were usable for analysis but because of the variety of respite interventions offered, a true meta-analysis was not possible. It was determined that “although caregivers often exhibit improvements in well-being during respite periods, these gains are short-lived,” suggesting the respite does not provide a long-term social support system (McNally et al., 1999, p. 13).

Social Support

Caregivers have identified a need for social support, which varies with an individual’s stage of life, length of time as a caregiver, and acuity and intensity of the caregiving situation (Norbeck, Chafetz, Skodol-Wilson,
& Weiss, 1991). A meta-analysis of 18 studies providing interventions for caregiver distress demonstrated that respite services and individual psychosocial interventions were moderately effective, and group psychosocial interventions were slightly effective (Knight, Lutsky, & Macofsky-Urban, 1993). In a literature review of the effectiveness of mental health interventions for long-term caregivers of highly dependent individuals, the authors concluded that psychosocial interventions promoting support and coping help reduce caregiver stress (Sowden et al., 1997). In summary, research literature provides a wealth of information on social support and its measurement, but it has not been tested as an intervention to prevent elder abuse.

**Batterer Interventions**

Vinton (1991) noted that abuse of women is evident across the life span, with the prevalence of spousal abuse decreasing with age. Batterer intervention programs to prevent further violence are available after the fact for individuals who stay with the perpetrator. However, a U.S. Department of Justice (2003) report summarizing the research literature indicates batterer intervention programs have positive results.

Batterer intervention programs are established and implemented based on different theories, including: men control their partners, the batterer has errors in thinking, and battering has multiple causes. Thus, programs vary in their focus and include helping batterers confront their attitudes about control, learn anger management skills, use cognitive therapy, use couples therapy, or a combination of these approaches. In 88% of the 34 programs offering cognitive-behavioral therapy, the re-offense rates were significantly lower in the treatment groups when compared with groups receiving no treatment (U.S. Department of Justice, 2003).

**Money Management Programs**

Intervention trials to prevent exploitation have not been completed, but daily money management (DMM) programs have emerged as a result of professionals in diverse settings observing their clients having exploitation problems. DMM programs assist people who have difficulty managing their personal financial affairs and include preparing checks, making bank deposits, dispensing cash, negotiating with creditors, maintaining home payroll for attendants, and calculating federal and state taxes. The roles of daily money managers are educators, client advocates, debt managers, bill payers, paying agents, representative payees, attorneys-in-fact, trustees, and guardians (Nerenberg, 2003).

Wilber (1991) examined whether DMM services would divert vulnerable older adults from conservatorship (legal arrangement under which an individual is appointed by the court to manage the affairs of an adult). Sixty-three community-dwelling adults ages 60 to 96 were assigned to usual customary screening or to money management groups. After 12 months of intervention, no significant differences in rates of conservatorship were found between the groups, suggesting the individuals who require conservatorship may be different from those who need DMM services.

**CONCLUSION AND IMPLICATIONS FOR GERONTOLOGICAL NURSING PRACTICE**

All health care providers should be aware of the risk factors for potential elder abuse and the various types of abuse. Many instruments are available for determining whether a person is at risk for abuse or is a victim of abuse. Differentiating the types of elder abuse and knowing the prevalence of each type may provide impetus for identification and development of specific interventions. Health care providers can benefit from use of the evidence-based practice guideline Elder Abuse Prevention (Daly, 2010), which offers suggestions for nursing diagnoses, interventions, and outcomes.

Unfortunately, few interventions have been tested to prevent abuse, and those suggested for use are from health care providers in various practice settings. Despite this lack of evidence, we have several recommendations. Consistent use by health care providers of well-established assessment tools to identify abuse or risk of abuse is critical and should not be seen as optional. Education and awareness-raising efforts should be ongoing wherever care and services are provided for older adults. Once risk for abuse or actual abuse has been identified, individualizing plans of care and service seems logical to decrease the risk for abuse or stop the abuse. Focusing both on older adults and caregivers is an essential part of intervening so that the family dynamics are addressed and appropriate support is rendered.

Another important aspect of elder abuse prevention, detection, and treatment is the need for an interdisciplinary team approach. Positive outcomes are more apt to happen with the entire team on board to assist older adults and their loved ones. As stated earlier, caseworkers who only investigated elder abuse reports had a higher substantiation ratio than caseworkers assigned to both child and elder abuse work. Having caseworkers for age-specific abuse or types of abuse, such as child, domestic, and elder may be warranted.

Safety is a basic human need and is an especially important consideration for older adults who are at risk for abuse. Nurses can lead the way in addressing elder abuse by using the evidence-based practice guideline Elder Abuse Prevention (Daly, 2010), helping older adults achieve the quality of life they deserve.
REFERENCES


of the American Medical Association, 280, 428-432.

ABOUT THE AUTHORS
Dr. Daly is Associate Research Scientist, Department of Family Medicine, The University of Iowa Hospitals and Clinics, and Dr. Schoenfelder is Associate Clinical Professor and Editor, John A. Hartford Center for Geriatric Excellence, The University of Iowa College of Nursing, Iowa City, Iowa.

The authors disclose that they have no significant financial interests in any product or class of products discussed directly or indirectly in this article. Guidelines in this series were produced with support provided by grant P30 NRR03971 (PI: Tom Tripp-Reimer, The University of Iowa College of Nursing), National Institute of Nursing Research, National Institutes of Health. Copyright © 2010 The University of Iowa John A. Hartford Foundation Center of Geriatric Nursing Excellence.

Address correspondence to Jeanette M. Daly, PhD, RN, Associate Research Scientist, Department of Family Medicine, The University of Iowa Hospitals and Clinics, 200 Hawkins Drive, 01290-F PFP, Iowa City, IA 52242; e-mail: jeanette-daly@uiowa.edu.

doi:10.3928/00989134-20111004-01