

SPECIAL ISSUE

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Indian Journal of GERONTOLOGY

A Quarterly Journal Devoted to Research on Ageing

Vol. 22, Nos. 3 & 4, 2008

Special Issue

on

Elder Abuse and Neglect

Guest Editor

Dr. Lynn McDonald

Director, Institute of Life Course and Aging
Professor, Faculty of Social Work, University of Toronto
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The manuscript should be typewritten on the one side of the page only, with double spacing and wide margins including titles, foot notes, literature citation and legends. Symbols formulae and equations must be written clearly and with great care. Too many tables, graphs etc. should be avoided. Each table should be typed on a separate sheet with its proper position marked in the text in pencil.

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References to several papers by the same author (s) published in the one year should be distinguished as 1969a,1969b,1969c,etc.

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EDITORIAL

This special issue of the *Indian Journal of Gerontology* focuses on elder abuse and neglect. This special issue consists of 16 papers from different parts of the globe that examine various dimensions of abuse and neglect as they are manifested in the different regions of the world. As the number and percentage of individuals 65 and over have increased in developed and developing countries, it is likely that the prevalence and the incidence of elder abuse will increase too, although there is a paucity of data to support this observation. Unfortunately, the nature of this growing problem has generally remained hidden from public view for a number of reasons. For example, the factors that may prevent the abused or neglected older person from reporting abuse or denying the occurrence of abuse include shame, guilt, fear, retribution or hopelessness. The abused person may have a fear of being abandoned or being placed in a facility if there is an allegation of abuse. He may also be afraid of retaliation by the abuser. While older people may not want to report elder abuse or neglect, there is also the problem that there has been limited research on the incidence and prevalence of the issue mainly due to its later appearance in the abuse literature in the 1980s following the discovery of child and woman abuse.

Elder abuse, also called mistreatment or maltreatment, is harmful behavior directed towards older persons by informal or formal caregivers who the older person loves, or trusts or on whom they depend for assistance. The destructive behavior can cause physical, psychological and material injury to the older person resulting in unnecessary distress, suffering and sometimes death. Elder abuse usually occurs in one of two locations: in the elder's home, usually called domestic abuse, and mistreatment in nursing homes or other long-term-care facilities referred to as institutional abuse.

Although there is considerable definitional disagreement about the type and nature of elder abuse, at least five categories have been identified with considerable disagreement about whether self-neglect or abandonment are forms of elder abuse. Physical abuse includes any act that involves the intentional infliction of physical discomfort, pain,

or injury. Examples of physical abuse include such behaviors as restraining, slapping, kicking, cutting, or burning. Medical maltreatment is sometimes considered an example of physical abuse. Sexual abuse or assault covers non-consensual sexual contact of any kind with an older person such as unwanted touching, all types of sexual battery like rape or coerced nudity. Psychological abuse, sometimes referred to as verbal or emotional abuse, involves the intentional infliction of mental anguish or the provocation of fear of violence or isolation in the older person. Psychological abuse can take various forms, such as name-calling, humiliation, intimidation or threats of banishment to a nursing home. Material abuse, often referred to as financial abuse, involves the intentional, illegal, or improper exploitation of the older person's material property or financial resources by the abuser. Material abuse can include fraud, theft or use of money or property without the older person's consent. Neglect generally refers to the intended or unintended failure of a formal or informal caregiver to fulfill any part of a caregiving obligation. Examples include failure to provide an older person with the necessities of life such as food, water, clothing, shelter, medicine or comfort.

Most recently, three new studies in developed countries report on the prevalence of elder abuse. In 2003/4 the First National Survey on Elder Abuse and Neglect under the sponsorship of The Association for Planning and Development of Services for the Aged in Israel (ESHEL) and the National Insurance Institute examined the prevalence and severity of various forms of abuse and neglect from a victim's perspective. Findings indicate that 18.4 percent of respondents were exposed to at least one type of abuse during the 12 months preceding the interview, the highest form being verbal abuse followed by financial exploitation. The UK Study of Abuse and Neglect of Older People, carried out by the National Centre for Social Research (NatCen) and King's College London (KCL), was commissioned by Comic Relief and the Department of Health. Over 2,100 people in England, Scotland, Wales and Northern Ireland took part in the survey between March and September 2006. Overall, 2.6 percent of people aged 66 and over living in private households reported that they had experienced mistreatment involving a family member, close friend or care worker with the most common form being neglect followed by financial abuse.

In Spain the First National Study of Elder Abuse in the Family in Spain, a random study carried out in 2006 found that .8 percent of the interviewees had experienced abuse by family members in the last year with the most common form being neglect and emotional abuse followed by financial abuse. In these three recent studies the rates vary substantially because definitions of elder abuse and neglect vary, cultures are different and, methodologies and timeframes for the occurrence of abuse differ and samples do not always accurately represent older people.

In terms of institutional abuse, a new study in Germany indicates that over 70 percent of staff reported in a random survey that they had behaved at least once in an abusive or neglectful way toward residents over a one-year period. Psychological abuse and neglect were the most common forms of abuse reported by over 50 percent of the sample (Goergen, 2004).

Efforts to advance social action to end elder mistreatment at a national level and to develop national policies and legislation are at varying stages of growth around the world as seen in this special edition of the *Indian Journal of Gerontology*. The United States has developed a full-blown national response to elder abuse at the state level that allows for the funding and reporting of elder abuse and has instituted at least three national organizations while other countries have been less proactive. In the light of this longer history, it is no surprise that the article, *Elder Abuse and Mistreatment: A Life Span and Cultural Context*, by Carey Wexler Sherman, Dorrie E. Rosenblatt, and Toni C. Antonucci, presents a new and innovative way to conceptualize the complexity of elder abuse using an intergenerational approach. The authors are of the view that the increased longevity is generally a positive development, but older adults and family members responsible for their care are often faced with associated problems due to such issues as chronic illness, family mobility and shrinking public and medical resources. Such factors strain the families' abilities to provide optimal care and increase the likelihood of elder abuse. The violation of a trust relationship, a defining feature of elder mistreatment, suggests that a consideration of social relations across the life span is useful for understanding elder mistreatment. Cultural expectations of intergenerational responsibility and assistance also influence perceptions

of and responses to elder mistreatment. This article examines social relations and culture as essential to a comprehensive understanding of elder mistreatment. Such understanding is critical to identifying risk, improving early detection, and providing sensitive intervention for elders in communities with increasingly diverse populations. Picking up a similar intergenerational thread, Ariela Lowenstein and Israel Doron in their paper, *Intergenerational Justice: An Israeli Perspective* emphasize the view that intergenerational equity is a central issue not only in gerontological theories but for the gerontological field at large. This article describes and analyzes the development of social welfare policies in Israel, in the context of intergenerational justice. The paper examines the developing themes of intergenerational justice in Israeli social policy, along with specific examples in old age with emphasis on the phenomena of elder abuse and neglect.

In Australia and Canada, various states and provinces have created mechanisms for dealing with elder abuse but there are no established federal policies about elder abuse per se. Both countries have national organizations dedicated to the termination of elder abuse which were established in the 1990s. In this issue three papers provide a window on Canadian responses to elder abuse and neglect. In keeping with the theme on legal issues, in the paper entitled, *Adult Protection Legislation: From intent to practice in three Canadian provinces*, Joan Harbison et. al., discuss the problem of mistreatment and neglect and governments' responses in the form of Adult Protection legislation. Their study is based on three rural communities in Canada where this act has been operative for the last twenty years. The authors find that there is a complex relationship between the provisions of Adult Protection legislation and the provision of assistance. In addition, there are many issues with regard to respecting the rights and autonomy of older people. The next paper addresses one of the most prevalent forms of elder abuse observed in many countries. Daphne Nahmiash and Rhonda Schwartz's paper, *A Community Response to Financial Abuse of Older Adults*, addresses the phenomenon of financial/material abuse of dependent older adults who live in the community where they are cared for by a family member, friend or neighbour and those living in a residential/nursing home where they are cared for by paid care givers. The article focuses on describing the types of financial and material

abuse that are perpetrated and also suggests how to avoid them. On a less traveled road in elder abuse, Drs. Clark and Goldlist, in *Protecting Vulnerable Older Adults in the Health Care System*, review the role of the *Geriatric/Long Term Care Review Committee to the Chief Coroner for the Province of Ontario* which has a mandate to improve medical care for the elderly in Ontario and decrease the occurrence of what could be construed as 'medical abuse'. The motto of the chief coroner's office, "We speak for the dead to protect the living," is most telling. The systematic review of problem cases in the care of the elderly with the creation and dissemination of annual reports has been an important method for improving the care of older people in Ontario and Canada.

In the United Kingdom there is a national body called Action on Elder Abuse that has stimulated government responses to elder abuse. The paper in this volume, *Abuse of Older People – The British Scene*, by Arup K. Banerjee provides an interesting overview of abuse and neglect in the UK. The various types and aspects of 'abuse' are outlined and the approach to handling suspected cases of abuse is discussed. Various international guidelines are mentioned and the latest UK Government actions are presented. The crucial need for more research in the field is emphasised – a case to be made for all countries - as is the importance of ongoing in-service education and training for professionals and carers. A number of regulatory measures recently taken by the UK authorities are mentioned. Above all, it is suggested that the need for an attitudinal change to old age will be of paramount importance. Norway has had parliamentary approval for services and a resource centre for research and information while France, Germany, Italy and Poland are at the point of recognizing the legitimacy of elder abuse and neglect. Found in this edition is a paper from Sweden, *Investigating Emotional Reactions to Elder Abuse: Pilot Study of a Triple Perspective Questionnaire* by Christen Erlingsson. The paper reports the results of a pilot study in Sweden examining lay persons' emotional reactions to a vignette concerning a potential elder abuse situation involving an elderly caregiver and his care receiving spouse. The participants rated emotional reactions from three different perspectives; how they themselves reacted, and how they thought the caregiver and the care recipient would each react emotionally. Emotional

reactions were explored through questionnaire items of anger, impatience, shame, disgust, concern, embarrassment, compassion, irritation, a desire to help, insecurity, and fright. Results showed differences between participants' own reported reactions and the reactions they expected the older persons to experience. These differences were especially noticeable between questionnaire versions. Analysis also indicated differences in response patterns that were related to participants' gender and marital/cohabitation status. This pilot study reveals several fruitful avenues for refinement of the questionnaire and for further investigation of emotional reactions to elder abuse.

The Latin America Committee on Elder Abuse has drawn attention to the problem within Latin America and the Caribbean while in Buenos Aires, the organization, Proteger, works solely with elder abuse cases. In Brazil, the Ministry of Justice, Health and Welfare supports official training on elder abuse. In Chile, a law against family violence was passed in 1994 which clearly addressed abuse of the elderly.

Turning to Asia, there have been several studies by researchers in Japan, India and the Republic of Korea about elder abuse and the beginnings of national organizations to fight the issue. South Africa established a preventive program on institutional abuse which was jointly sponsored by the government and the private sector in 1994 while the Nigerian Coalition for the Prevention of Elder Abuse facilitates the meetings of professionals working with older adults. This volume of the *Indian Journal of Gerontology* is particularly rich in reports from India and is the heart of the journal for those struggling with the problems of abuse and neglect in India.

Looking specifically at India, many years ago, the elderly had a special place in the family and in Indian society. The elderly were loved, cared for and respected. Their thoughts and opinions were considered to be of immense value, something every young person would look up to. Over the years, however, there has been slow and gradual erosion of this view of the elderly. For a number of reasons, older adults have faced growing covert dissidence, a form of subtle defiance from the young and society in general which, in some instances, can lead to elder abuse or neglect. For example, through retirement or loss of productive capacity and hence the ability to be independent, older adults

are exposed to a high risk of being abused and neglected. In some instances, living in long term care facilities due to frailty or the death of spouse may lead to depression, enhancing the chances of becoming a victim of abuse or neglect. In such situations the care givers fail to recognize the problem or provide the victim with emotional support.

An important case on point are widows in India. Most of the widows in India face much insecurity and dependence in old age. They have been dependent on the earnings of their husbands and after the death of their husbands they have to search for alternative means of survival. Therefore, those who have lost their husbands are more prone to social isolation and a decline in status in the family. More traditional upper class Hindu society imposes very strict restrictions on a widow's life style so that such an extreme transition into old age will surely be a major problem for many women. These women have to adapt to substantial changes in the patterns of their lives that they had previously pursued. The plight of rural widows is even worse than that of urban widows. Urban widows sometimes receive a retirement pension and life insurance benefits from their deceased husbands. In contrast, rural women rarely have this advantage because rural men do not easily find a job in the organized or core sector of the economy and cannot contribute to life insurance policies.

Following these themes, the paper, *Determinants of Elder Abuse in Rajshahi City Corporation, Bangladesh: Evidence from a Micro-Level Survey*, by Md. Ismail Tarque *et al.* presents a disturbing finding that in Rajshahi City Corporation, 17 percent of the elderly are abused. Their study shows that most of the abused elderly were the young old, widows and the illiterate. The overall finding of this study also suggests a close relationship of abuse with the family head, physical condition of the older person, living arrangements and educational background. The authors recommend that this knowledge needs to be utilized in developing suitable programs addressing the abuse of the elderly in the country. The researchers emphasize the importance of replicating this research, and incorporating culturally specific findings into customized intervention strategies, an important suggestion given the ethnic diversity of India.

An important issue in understanding global elder abuse is that of cross-cultural differences. Addressing Asian communities in the United States, Rashmi Gupta and Anoshua Chaudhuri's paper, *Elder abuse in a Cross-cultural context: Assessment, Policy and Practice*, examines the concept of elder abuse in a cross cultural context. The authors are of the view that elder abuse is evidenced in the form of silent treatment, neglect, social isolation, and exploitation. Practitioners often associate elder abuse with physical violence, but analysis of reported abuse in the United States demonstrates that financial abuse is more common. Elder abuse is widespread but it is often under-reported as it is difficult to assess and prevent, especially in Asian communities in the United States and in South Asia. The importance in understanding the link between the countries of origin and the host countries in elder abuse is underscored in this study.

Selecting the caregiving theme, Roopalekha Jathanna P. N., and Latha K .S. in their paper, *Care Giving and Caregiver Stress: A Case Report*, examine the issues of elder abuse in a caregiver setting where patients suffer from dementia along with others with severe physical and psychiatric disabilities found in the data from their long-term project. In addition, the stresses and strains experienced by informal caregivers of the persons with dementia are highlighted. K.S. Latha in her paper entitled, *Elder Abuse and Neglect: A Review*, emphasizes the widespread and serious problems of elder abuse and neglect and the factors which contribute to elder abuse, the reasons why it is not reported by the victim, the characteristics of the abused and the abuser, manifestations of abuse and management issues thereby providing an excellent overview of the issues. U.C. Jain, in his paper, *Elder Abuse: Outcome of Changing Family Dynamics*, traces the pattern of increasing elder abuse amidst changes in Indian family structures and functions. The short case studies reported by the author indicate that older adults are encountering both physical and psychological distancing in joint as well as in nuclear families. The paper also explores the possible solutions for such a grave social problem.

Moving to an institutional setting, Varsha Pandya in her paper, *Resolving Elder Abuse Complaints in Homes for the Aged: Relevance of an Ombudsman Program*, provides information on the Ombudsman Program in the U.S. and other European countries for

consideration of Indian stakeholders in the development of homes for the aged. The article also provides alternative models, processes and potential pitfalls of these to guide the decision-making for program development. According to Mala Kapur Shankardass in, *Critical Understanding of Prevalence of Elder abuse and the combating strategies with specific reference to India*, elder abuse has only recently been a subject worthy of serious academic inquiry and concerted action in India – a situation seen around the world. However, absence of valid statistics and systematic collection of facts related to the problem contribute to it being still under recognized and insufficiently acknowledged. Lack of conceptual and definitional clarity as well as under reporting comes in the way of finding ways and means to combat it. Understanding abuse of older people and finding solutions to deal with it is further complicated by social taboo among older people on discussing the subject and consistent denial by family members that abuse takes place in their homes. Yet another difficulty is that not all of the situations characterized as abuse fit into existing legal categories. Consequently, little attention is being given to elder abuse as a major social issue. Even less effort is being devoted to tackling the underlying causes of elder abuse and developing appropriate interventions and adopting combating strategies. This paper reviews the prevalence of elder abuse and strategies to end the abuse in the Indian context based on the author's research, academic interest and engagement with the subject as an activist.

Considering widows, Madhurima in her paper, *Elderly Widows as Victims of Physical Abuse: A Qualitative study in the state of Punjab*, emphasizes that due to changing age pyramids, value systems and withdrawal of family support systems, domestic maltreatment of the elderly in India is emerging as an important social problem. The institution of joint family systems, caste and village community, which formed the building blocks of the traditional structure in India, assured economic and psychological security and high social status for the aged who are now at the mercy of their son(s). This problem can be better understood from a dependency framework as older widow's investment in the ideals of family are quite high. Their social reality has not been constructed outside family living. It comes as a rude shock to them when they are physically abused by their sons or have to leave their

family to seek support from formal agencies as a last resort. The concluding paper by Anupriyo Malik entitled, *Narratives of Aged Widows on Abuse and Neglect*, is fittingly based on in-depth interviews with elderly widows residing in various old age homes in Kolkata and its adjoining areas. The paper portrays the suffering and humiliation of the widows in terms of the abuse and neglect they experience and there is no more eloquent commentary on the tragedy of abuse and neglect than their own words.

Throughout the world, abuse and neglect of older persons is largely under-recognized or treated as an unspoken social problem. Regrettably, no community or country in the world is immune from this expensive, public health and human rights problem as witnessed in the articles that appear in this special edition. The *Indian Journal of Gerontology* is exemplary in recognizing this transgression against older adults around the world and should be commended.

Lynn McDonald

A Community Response to Financial Abuse of Older Adults

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ABSTRACT

This article addresses the phenomenon of financial/material abuse against dependent older adults who live in the community and are being cared for by a family member, friend or neighbor or who are living in a residence or nursing home and cared for by paid caregivers. It is hard for us to imagine that such abuse exists and in fact, has always existed in our society. Violence against older adults is yet another manifestation of domestic violence, about which we, as a society, are becoming more and more aware. It is important for all members of society, as well as health care professionals, to be aware of the signs and symptoms of this phenomenon so that we can find ways to detect the presence of such a problem and thus enable the victim to get the help they need. As well, we need to find ways of preventing such abuse from occurring. Therefore, this article has focussed on describing the types of financial and material abuse that are perpetrated and how to avoid them.

The article will first explain the prevalence of the overall phenomenon of abuse in general against older adults. Definitions will be addressed next, including the difficulties in arriving at a common terminology. We will then focus on financial and material abuse which is the most common type of abuse reported in Canada. We will present a brief review of the literature which highlights how financial abuse has been described and some attempts to prevent the problem

throughout Canada and the USA. A brief discussion on the probable causes will follow including why seniors do not report such crimes. Next, we will present a case study of a small community's attempts to educate seniors about the possible incidents of abuse in the home and on the street using a community development model based on the principles of empowerment. Finally, we will draw some conclusions from the study and the model which could be useful for other community organizations in the prevention of such abuse.

Prevalence

Why are we talking about financial/material abuse toward older adults right now? Is the phenomenon more prevalent than it was? It is important to note that such crimes against older adults are not a new phenomenon. In fact, a recent study from Greece (Pitsiou-Darrough and Spinellis, 1995) notes that "*ancient Greek history reveals clear cases of selfish carelessness or coarse insolence toward the old and offers instances of children taking over their parents' property..... without proof of incapacity in the elders*"(p.45). We also note that all types of abuse and neglect of older adults have only come to the attention of researchers and practitioners in the past three or four decades. However the first national Canadian study notes that approximately one in 25 older persons (over the age of 65) are victims of abuse and neglect (Podnieks et al, 1990). Similar estimates have been made for the United States (Select Committee on Aging, 1981). In the past three decades more and more countries have been identifying the problem and finding ways to bring it to the public attention. A British study observed that work on abuse of older adults has been reported in 22 European countries (Council of Europe, 1992) even though much of the work is still in the formative stages. One author has compiled research from ten countries in different parts of the world from international and cross-cultural perspectives (Kosberg and Garcia, 1995). The same authors conclude that the problem will probably augment as a worldwide social problem as populations are aging rapidly and the number and proportion of older adults are increasing, especially the oldest of the old.

In spite of all this, few studies have actually measured the incidence or prevalence of the phenomenon. Of those studies which have

attempted to measure the problem, the descriptions vary according to the methodology used. For example, it is difficult to distinguish in the studies between incidence and prevalence of cases. North American studies however, do seem to agree that between 3-5% of persons over the age of 65 years are victims of abuse and/or neglect (Podnieks et al, 1990; Tatara, 1993). In the United States alone, this represents over one million persons. Thus, we can say that abuse of older adults is a serious social problem and practitioners should be aware of its existence in order to identify, treat and prevent it. Authors have also noted in all studies that the phenomenon of abuse and neglect is extremely taboo among the older population and rarely reported. The reported estimates of 3-5% are probably underestimated since most cases are hidden and difficult to find. For this reason, it is extremely important that doctors and health care professionals become familiar with the signs and symptoms of suspected abuse. Next we will define what we mean by the terms “abuse” and “neglect” of older adults and what we mean by “caregiver abusers”.

Definitions of abuse and neglect

Definitions of abuse and neglect are problematic, since there are no agreed-upon intrinsic or extrinsic definitions nor are there standardized conceptualizations of the phenomenon as yet, although several authors have attempted this, including Hudson and Johnson (1986) from the US and Stones (1991) from Canada. Definitions are nevertheless important to give a clear understanding of the problem in question and differentiate that area of concern from others. One of the main reasons why definitions differ is that their meanings are interpreted differently by each researcher, depending upon the purpose of the study. Some people use the word “mistreatment” and others use the term “abuse and neglect”. The World Health Organization offers the following general definition of abuse: “a single or repeated act, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person.” (WHO, 2002). In the same document, relationships of trust are referred to as those between a senior and a family member (immediate or extended) and friends, but also include those in which an older adult relies on someone for care or services in a paid relationship,

for example, a financial advisor, home care provider or medical professional. A Canadian framework for defining abuse and neglect is described in the EAST tool, which contain 71 items grouped into the following nine categories (Stones, 1995): physical assault, excessive restraint, putting health at risk, failure to give care by someone acting as a paid or unpaid caretaker under pressure, humiliating behavior, abuse in an institution, material (includes financial) exploitation and verbal humiliation. Stones found high agreement among seniors and professionals on items that indicate greater or lesser abuse and the items rated as most abusive by seniors were mainly examples of physical abuse. However, most researchers have opted to use the following definitions to operationalize the types of abuse and neglect encountered (Podnieks et al., 1990; Pillemer and Finkelhor, 1988; Pillemer and Wolf, 1986; Kosberg, 1988). They are as follows:

Physical abuse: hitting, burning, assault, rough handling.

Sexual abuse: any form of assaulting the person in a sexual way or forcing them to perform or engage in any sexual activity against their wishes.

Psychological abuse: when an older person is subjected to repeated or chronic verbal assaults which insult, threaten, humiliate or exclude. This also includes lack of affection, social isolation or denying the person the chance to make or participate in decisions which are in their own interests are included.

Material/financial abuse: misuse of money, possessions or property. This includes fraud or using an older adult’s funds for purposes contrary to their needs and interests.

Passive or active neglect: the withholding of items or care necessary for daily living, and can be intentional (active or physical) or nonintentional (passive).

Self-neglect has also been identified as a form of abuse. It consists of a person’s failure to provide adequate care for him/herself. This form of abuse is different from the others in that there is no abuser involved. However relatives or others may be aware of the problem and fail to help.

Violation of a person's rights has also been recognized as a form of abuse. This consists of forcing a person to do something against their wishes or preventing them from making their own decisions, such as forcing them to go to a nursing home. Other authors include this as part of psychological abuse.

Social, systemic or collective abuse: a societal form of abuse. It includes ageism and other ways of treating elderly persons which affect their personal dignity and identity. This type of abuse was highlighted in a British study, which pointed out that abuse and neglect are socially structured through a range of policies and professional ideologies relating to dependency in old age (Biggs, et al., 1995).

A knowledge of all types of abuse and neglect is important in this study of financial abuse as rarely do we find only one type of abuse present against older adults (Nahmiash, 1997).

Finally, it is important to note that multicultural or aboriginal groups may define abuse and neglect in different ways. This is particularly relevant to this article as the case study example was done in a multicultural community in Montreal. Most studies ignore these cultural aspects and seem to assume that all older adults are similar in their attitudes and perceptions. Primary prevention programs, such as the one cited in the case study, need to pay attention to these aspects as each society and group has different standards and norms about what constitutes abusive and neglectful behavior. Most standards and norms regarding financial and material abuse are laid down in the criminal code or the charter of rights of the country, but other types of abuse may be defined by common consensus of the society or group. Psychological abuse and neglect or self-neglect tend to mostly fall into this latter category. Having defined the different types of abuse and neglect, we will now focus specifically on financial and material forms of abuse.

Examples of financial/material abuse of older adults from case studies:

The following case studies describe incidences of financial and/or material abuse and also hint at some possible causes and explanations for the abuse.

An 83 year old father is abused by his son who persuaded him to sign over his house with a promise to take care of his father. After the father no longer owned his home he told the interviewer that the son "sold his house, he told me he'll invest his money in something...so he had to buy some stocks (Did you know about this and agree to it at the time?)" "No, I was too stupid... everybody took advantage of me. And I feel that he took advantage of me and now he doesn't need me so he doesn't bother with me". The father told the interviewer how powerless and isolated this made him feel (Nahmiash, 1997). The case also hints at the abuser's explanation for his actions which can be noted as money or material possessions being a fair exchange for care in his son's eyes.

A daughter and son-in-law (both substance abusers) also took over their mother's property. They told the interviewer it was a gift and put the house in their own names. She describes it this way. "She (the daughter) broke into my house. She used her key...and stole...out of my purse". The daughter justifies her behavior by stating: "I have heard how she ...had to pay off her mortgage and how I've never paid her back. I didn't ask her to do that and I have no intention of paying her back. She did what she did. It was her choice and to me it was a gift....I will say she did give a lot materially, but all unsolicited. There were times when I did ask, yes, but the majority of time it was all unsolicited and it was the way my mother kept control."

It is interesting how the daughter feels no remorse for her abusive behavior toward her mother but justifies it and blames her, which conforms with Tomita's (1990) neutralization theory that abusers often justify their crimes.

A third example shows how some young stepchildren stole from their elderly father. "The kids started stealing from me and then ...would tell me to go ahead find out who is stealing...money...clothes, from the bureau, from their mother's purse...and they would do charity work and steal from the donations...overwrite them then sometimes they would say "You're not my father" and I was the one giving everything. I paid all the expenses...and I didn't like the stealing."

The abusive stepdaughter also went to see a legal counselor to get advice about how much money she was entitled to from her stepfather. She said that *"she could take half of everything, half of my (the stepfather's) savings, half the furniture...the insurance...I felt I was betrayed by the oldest girl. She kept asking and she thought "well this is the way I'll take her (the girl's mother) away from him."* In this example, we see how the child's explanation for her abusive behavior was to get back her mother from her stepfather who she felt was too old and senile to fight back. *"Now look, you're going cuckoo, you're losing it. You're going senile..." sort of like telling me you're not thinking properly."*

Thus, the girl justifies her behavior through ageist comments which support Robert Butler's (1989) conclusions that in some cases, old age is equated by society with powerlessness and uselessness as a result of disease, disability and uselessness. Butler (1989) defines ageism as *"reflecting a deep-seated uneasiness on the part of the young and the middle-aged, a personal revulsion to and distaste for growing old, disease, disability and a fear of powerlessness, uselessness and death"* p. 243.

Ageism was also described as the only cause in the following case example concerning financial and material abuse:

A young couple bought a house and moved next door to a couple of older adults. Subsequently they went to extraordinary lengths to abuse and get control of part of the property and land belonging to the older couple. The case was brought to court by the 78 year old lady whose husband was disabled. She fought back bravely for over two years using the criminal justice system with little success. The only explanation for the behavior of the abusers seemed to be that the older couple was, in the opinion of the younger, too old to fight back. The abused lady describes her experience as follows: In response to the abusers saying *"You know we have a right to do these things. We are young and work hard"*, the abused lady replied: *"I said Mister; we have worked all of our life. This is our home.... He (the neighbor) would do crazy things so we couldn't get out. It was like that for three years.... We were stuck. They hosed us in our yard, spat in our yard, waited for us at 10:00 at night....She started to mark the property with white paint...They built a fence....We tolerated, we*

endured. If it would have been somebody young, that would have thrown them. They would have had to face them, but they knew they were dealing with a crazy old woman...and (an) old man so they took advantage of it. They've hurt my health and made me incur expenses...I believe its going to go up to \$10,000 because they know we were old...and to be gone soon".

This example demonstrates how ageist attitudes can directly contribute toward abusive behavior and how a younger couple can justify such behavior by such attitudes. Furthermore, the ageist attitudes were condoned by the very societal protection system, i.e., the criminal justice system, put in place to protect them, since after three years, the older couple did not resolve the case against the abusers and asked to be placed in a nursing home. The lady finally states, *"How can it (the criminal proceedings) take so long, cost so much and make me suffer (she was hospitalized on account of the lengthy court proceedings)?"* Her conclusion was *"There is no justice"*.

How do we know if an older person is a victim of financial abuse?

Most seniors are reluctant to report abuse or neglect of any kind especially if it is perpetrated by a family member. The reasons for this include the fear that they will lose the important relationship they have with that person and the fear of their family's reactions to the abuse being made public or ashamed of what is happening and their inability to prevent it. Abuse of older adults is like all forms of violence: it is kept as a well guarded family secret. They also find it difficult to ask anyone outside the family for help. One victim of abuse expressed it this way: *"Tell the Doctor what happened....I didn't think Doctors were interested in this , you know, family affairs."* Another stated, *"I know sometimes you have to have someone to talk to but this woman was outside the family"*. A third person put it this way, *"Some things are better not said...I was really scared to tell anyone...I just kept it to myself."*

In spite of the reluctance of victims to talk about financial abuse, there are some signs of abuse which friends, neighbors and health and social service practitioners can be aware of to detect whether abuse is occurring or not. If they do observe such signs, they need to ask further questions about the missing objects or money.

Here are some examples of the signs :

- Loss of money, bank books or checks;
- The signature on checks does not resemble that of the older adult;
- Bank statements are no longer coming to the person's home;
- Sudden unexplained or large withdrawals from the bank;
- Sudden inability to pay bills or buy food or clothing;
- Receives incorrect change from person purchasing food or goods;
- Loss of jewelry, silverware, paintings, furniture or sculptures;
- Unprecedented transfer of money or property;
- Someone is pressuring the person to sign legal papers (such as a will, a power of attorney or a joint deed to the house);
- A new will is drawn up and the older person did not agree to change it;
- The older adult is not being allowed to make decisions or speak for him or herself;
- The person is not in close contact with family or friends;
- The person is afraid or worried when money is mentioned;
- Power of Attorney or mandate is improperly obtained (from someone who is mentally competent).

Review of the literature concerning financial abuse

There is not a great deal of Canadian literature in scientific journals specifically about financial abuse but this brief review will document a few of the points emerging from the existing articles. Financial exploitation was noted to be the most frequently reported form of elder abuse by older victims of abuse in the large national study done through telephone surveys by Podnieks and her colleagues (Podnieks *et al.*, 1989). However, in the Pittaway (Pittaway *et al.*, 1995) study from 489 files of elder abuse cases, financial abuse was only observed to be the third largest form of abuse representing 26.6% of the abuse and neglect cases. (Psychological and physical abuse were the most frequent.) Finally, the Project Care study (Reis and Nahmiash, 1995)

showed that financial abuse was the second most frequently documented among abuse cases.

In 1992, Spencer began a two year study in British Columbia investigating financial abuse among 200 seniors. She found that 8% of older adults had been financially abused, losing, on an average, approximately \$20,000 each (Spencer, 1994). Some forms of abuse, in particular financial abuse, constitute crimes and fall under criminal and civil legislation acts. As well, approximately one quarter of all crimes against older adults are committed by family members, usually a spouse or adult children. The consequences of abuse usually lead to depression and serious health problems associated with highly stressful living conditions. In the case of financial abuse, loss of housing, poverty and other economic costs are also related (Federal/Provincial/Territorial Committee of Officials(Seniors)2005). Abuse and neglect has been found to significantly shorten the lives of older adults. Substance abuse problems (including gambling) and mental health problems are factors occurring in up to one third of cases (Federal/Provincial/Territorial Committee of Officials(Seniors)2003). Many forms of abuse also involve tangible and intangible social and economic costs, such as costs to health care, community services and the justice systems (Spencer,1999), as well as to the older victims themselves. However the exact costs cannot yet be measured due to the lack of consistent definitions being used, the lack of standard services for abused older adults, the lack of reliable data and the lack of standardized information collection practices (Federal/Provincial/Territorial Committee of Officials(Seniors), 2005).

In spite of the dearth of scientific studies on financial abuse over the past few decades, a surprising amount of programs have recently been established across Canada to prevent and intervene in cases of abuse and neglect. Abuse and neglect have been identified and prioritized by the Federal Government of Canada and most provincial and territorial governments as an important social and public health problem or as part of overall family violence prevention programs. As well, World Elder Abuse Day is observed across Canada to offer widespread education and public awareness about elder abuse. A number of prevention, education and intervention approaches exist, though few have been evaluated scientifically to measure their effectiveness.

Prevention approaches include models, such as the Community Response Networks in British Columbia, Alberta Elder Abuse Awareness Network, the Ontario Network for the Prevention of Elder Abuse and the Quebec Network against Elder Abuse. We can also note that many provinces, for example, New Brunswick and Nova Scotia, have produced manuals and educational materials for the prevention of fraud and scams and other forms of financial abuse which have been used widely across Canada. Most provinces have strategic plans to provide programs, such as outreach, education and Public Awareness Campaigns.

In terms of interventions, the main approaches used have been adult protection models, domestic violence models, advocacy programs, integrated models and coordinated community approaches sometimes based on multidisciplinary teams offering a range of services, such as home care. Several provinces provide emergency shelters, crisis intervention or family therapy service programs for victims of elder abuse. As well, some provide assessment and counseling teams, telephone hot lines and support groups.

It should also be noted that programs are offered in the Yukon and the North West Territories to offer emergency shelter and education to victims of abuse.

The principle laws enacted in Canada to help victims of crimes, such as financial and material abuse are as follows: adult protection laws (primarily in the Atlantic provinces), adult guardianship, human rights laws (in Quebec), family violence statutes and criminal law. An innovative community legal clinic for low income seniors offering legal advice and services is the Advocacy Center for the Elderly established in the 1980s in Toronto (Federal/Provincial/Territorial Committee of Officials (Seniors) 2003).

In spite of these available laws to intervene in cases of financial abuse, a recent study showed that most health care practitioners and seniors do not use the legal recourses and are not informed about them even though legal services could resolve most of the cases. In fact, there was agreement that financial abuse cases would be more likely to be resolved through the justice system than cases of other types of abuse (Noreau et al. 2007).

In spite of all of the above programs and interventions, few articles if any, have evaluated the innovative community approaches to prevent financial abuse and neglect from occurring. For this reason we will next present a small evaluated Canadian community project to demonstrate how information can be provided to seniors with measurable outcomes for success.

Community case study – “Partners Against Crime”

Background and context of the study

In the west end of Montreal, a small community-based organization, Notre-Dame de Grace Community Committee on Elder Abuse (NDGCCEA), designs and implements programs with the objectives of providing education about abuse of older adults to help reduce the incidence of this abuse occurring. During 2001-2002, they compiled and analyzed statistics to explore which crimes were reported as most frequently perpetrated against older adults in the area. The study was undertaken by the Community Service police officers from the local police station, who sit on the board of this organization. The area of Notre-Dame de Grace had a population of 64,675 residents, of whom 12,945 persons were over the age of 60 years (CLSC NDG/Montreal Ouest, 2003). As well, since 1996 there has been an increase in the number of people who are 85 years and older in the area. This population group will continue to increase in number and represents the most vulnerable group in the community. We should also note that the proportion of people over 65 years in the area is 18% higher than in the overall Montreal region. A high number of the residents are low-income, and the areas of low cost housing are at increased risk for criminal activity and security problems (Plamondon and Nahmiash (2006), according to the police and the residents, creating a higher-risk situation. The case study also examined who were the perpetrators of such crimes against older adults as well as the types of crimes reported. The results of the study showed that 166 crimes were committed against 166 seniors during this period, representing 5.5% of the total number of seniors in the area of Notre Dame De Grace at the time of the study. 20% of the crimes against older adults were perpetrated by young persons, most of whom were between the ages of 15-16 years. It was also noted that this percentage (20%) represents a total greater than the total percentage

of youths in this age category (between 14-25 years) in the population of this area (14.3%). The average overall age of perpetrators was 37 years for males and 39 years for females. However, this percentage includes a few persons who were over 60 years of age which elevated the average age of the group. The types of crimes reported and perpetrated against older adults fell mainly into two categories. The first included thefts and breaking and entering (clearly forms of financial abuse), while the second category included assaults and assault with a weapon or threats against older persons, including purse snatching. Fraud and other types of financial abuse were also reported. Even though the crimes against older adults are relatively few compared to the overall crimes in the area, few crimes against seniors are actually reported due to fear and lack of awareness of those in the community who can provide assistance to them. In fact, some seniors feel forced to move to another community to avoid what they perceive as dangerous environments, thereby removing them from their familiar surroundings and creating a new insecure and isolated situation (Brillon, 1987). It has also been reported that the impact of such crimes on older adults (particularly older women) is far more severe than on younger adults (Brillon, 1987). The fear and insecurity of becoming a victim contributes to social isolation, depression and loss of mobility, which all affect the physical and psychological health of the seniors. These factors all contribute to a cycle of fear, vulnerability and increased risk of becoming a victim.

A second small qualitative study found that a number of unreported incidents were also observed by members of the NDGCCEA (reported by a local bank representative and a legal expert) which show how financial experts have a difficult time assessing when financial abuse occurs:

An elderly client, who has substantial savings in her account, appears frequently before a bank teller and is visibly confused. Friends sometimes accompany her. The bank teller does not have enough knowledge to be able to judge the mental capacity of the client to assess whether she is competent to decide to make the withdrawals from her account or if she is being influenced by her companions.

A son accompanies his elderly mother to the bank every month at which time all money is removed from her account. Bankers are limited

regarding what they can do when they suspect an elderly client may be financially abused due to the fact that the client is a fully capable person who has the right to make her choice.

An elderly person sends a neighbor to perform all her banking needs through the ATM machine by giving the neighbor her bank card (and PIN number) and money to deposit.

Following the study, it was decided to develop a program to run over a period of one year, whose goals included the prevention of crimes against older adults by empowering them with the necessary skills, information and tools to in order to raise their awareness and knowledge of potentially abusive situations. The organization had previously been successful in offering (and continues to offer) educational workshops in high schools to address the issue of ageism among 14-15 year old youths, and to provide positive experiences with older adults and positive images of older adults (Joining Generations, 2001).

Objectives of the study

The project "*Partners Against Crime: A program to help prevent financial and material abuse*" (NDCCEA, 2007) involved a collaborative partnership with the NDGCCEA, local community police officers, Tandem Montreal (an organization which provides security services to the community), a representative of the Royal Bank and students from the McGill School of Social Work. The project was presented in five low-income housing units in the area of Notre-dame de Grace, with each building having approximately one hundred tenants.

The specific objectives of the project were to-:

- provide seniors with the knowledge, skills and tools to safeguard their finances, property and person;
- reduce fears and insecurities so that their safeguarding measures would be appropriate;
- reduce fears and insecurities to increase the chances that they will report crimes/abuse to the appropriate authorities;
- provide past victims with the knowledge, skills and tools to prevent further incidents (since a high number of such victims are repeat victims).

It was hoped to meet the objectives by empowering seniors with the knowledge and skills that would prevent them from becoming victims. It has been observed that education is not only about acquiring information, but is also about changing attitudes, behaviors and values. Thus, education is one of the most significant primary preventative interventions in elder abuse and neglect (Gallagher, 1993; Podnieks et al, 1990; Podnieks and Bailey, 1995).

Description of the study

The project was designed and adapted from an unpublished model entitled "Community Organization Process" from the CLSC NDG/Montreal Quest with the following steps:-

- Development of a preliminary understanding of the needs of the community and the problems defined by the community, based on a previous study done by Plamondon and Nahmiash(2006), exploring the needs and characteristics of tenants living in low-income housing units (Plamondon and Nahmiash(2006).
- Assessment and analysis of the articulated needs in relation to the well being of and potential risks toward the residents in the buildings;
- Project development and planning phase - included establishing priorities, adjustment of project goals, determination of target population (selection of residences), definition of project activities and strategies, definition of indicators of success (measurement tools), definition of implementation procedures, definition of evaluation procedures and determination of resources required for implementation.
- Project implementation phase - included development of partnerships and joint community actions, provision of technical and supportive assistance to facilitate community participation and capacity building;
- Evaluation analysis and dissemination of the project - included production of reports and recommendations, DVD's and presentations to scientific conferences and journals.

The project provided three educational presentations in five different buildings about banking issues, safety on the street and safety in the home for a total of fifteen two-hour sessions. Times and dates were selected based on the recommendations of the Tenants' Committees in each building. Included in each presentation were theatrical comedic skits performed by animator/actors. The use of theatre was based on the rationale that an animated production with interactive dialogue would have a greater impact on the senior audience's memory and understanding of the concepts and skills associated with the prevention of financial/material abuse as the use of drama or drama skits as educational tools has proven to be very effective amongst seniors (Podnieks and Bailey, 1995). The aim was to empower seniors to make appropriate decisions and be aware of potentially risky situations. Furthermore, the empowerment would reduce fear and anxiety, enabling them to attend to their normal daily activities, a crucial aspect of their well being. The presentations would sensitize the participants to the issues of elder abuse in a learning environment which would help them to feel less vulnerable, powerless and fearful. To evaluate the effectiveness of the project an objective evaluator was hired to design and administrate pre- and post-questionnaires for each presentation at each locale in an effort to determine how much was learned by the participants.

Empowerment concepts and community development principles which support the community case study.

Some underlying concepts and principles underline the work of the NDGCCEA and this project. They are as follows:-

This small qualitative project described above in the case study is based on the hypothesis that powerlessness in older adults is due to inadequate financial and material resources, as well as unhealthy attitudes toward older adults, and may contribute to their being in abusive and neglectful relationships with their caregivers. The project draws on the ecological approach of Bronfenbrenner (1989), Seligman (1995) and Schiamberg and Gans (1999) which provides a framework for studying the contextual interactions between the individual, interpersonal and environmental risk factors leading to abusive and neglectful behavior in older adults in a family context.

Bronfenbrenner (1989) states that studies of the context, environment and resources present in a person's life course can affect whether or not the person will be in a position of helplessness and powerlessness which can lead to an outcome of abuse and neglect. Seligman's profound work with children found that an individual's learned explanations of behavior are influenced by whether they learn pessimistic explanations (which produce hopelessness and passivity in the face of failure) or optimistic explanations (which see failures as challenges). He also demonstrates that such learned explanations and responses are produced by the environment in which a child is raised. Additionally, significant events in a person's life span, such as the death of a parent, physical abuse, severe parental strife or sexual rejection during adolescence can change the person's optimistic world view to a pessimistic one (Seligman, 1995). Few researchers have attempted similar studies in relation to older adults. This project attempted to change some learned behaviors of the seniors to prevent abuse from occurring through giving them information and knowledge about other alternative behaviors to choose from when they are at home and on the street or in other areas such as restaurants.

However, maximizing resources to persons who are powerless, oppressed and have unequal access to such resources has often been also stated to be an important goal in empowerment concepts (Kieffer, 1984). The relationship between absence and presence of resources has been noted to be relevant in studies related to care giving as influencing coping strategies and outcomes of continuity of care (Vezina and Roy, 1996). For example, studies have noted that less assistance is offered by the health care providers in the public sector in cases where there is a family member available, despite the fact that such expectations create a considerable burden for the family (Garant & Bolduc, 1992). For this reason hand outs containing information about assistance and resources were distributed to the senior participants after the project was completed. The seniors were personally introduced to community police officers, bank and security representatives to enable them to feel less fearful about using these resources.

Powerlessness in this project is conceptualized as a continuous interactive process between the abused persons, the abusers and their environment. This relates closely to Seligman's definition of a pessimistic

world view in which depression is often present. Depression has been observed to be often present in abusive and abused older adults (Paveza et al., 1992). Powerlessness is expressed through attitudes of self-blame, a sense of generalized distrust, a feeling of alienation from resources and a sense of hopelessness and discouragement (Kieffer, 1984).

Empowerment is conceptualized as an outcome of intervention or personal strategies to assist an abused older adult in moving out of this process of powerlessness. Empowerment is defined as a process of *helping people assure or reclaim control over their destinies, which entails maximizing their confidence, skills and abilities and making informed decisions that are in their best interests, having access to choices and available, accessible resources and options* (Health Canada, 1993) *for the attainment of both personal and collective goals* (Nahmiash, 1997). Empowered persons would express an optimistic world view and would have mastery and control over their lives as opposed to suffering from depression and feeling they have no control.

The project focuses on whether or not it was possible to empower the seniors through knowledge and information in order to prevent them from becoming powerless in a potential situation of abuse.

Evaluation of the project

The goal of the evaluation was to assess whether the project objectives were met. This implied assessing the impact of the presentations on the senior's knowledge as to whether they learned the appropriate behavior to adopt when confronted with situations which may present a risk of financial/material abuse.

A secondary objective was to assess the appreciation of the participants for the presentations concerning their perception of whether their knowledge of appropriate behaviors had improved and whether they would recommend these workshops to family members, friends or neighbors.

Methodology

Three questionnaires were developed, one for each of the three sessions. They were based on the information submitted in advance by

the presenters. The questionnaires were on one page, contained a limited number of questions that could be answered rapidly, were easy to understand, mostly multiple choice, written in large characters to facilitate reading and allowed the possibility to determine whether participation in the sessions had an impact on the participants' answers. These included a comparison between before and after, and provided an assessment of the participants' level of appreciation of the training.

Each questionnaire had 5-6 questions on the topic of the presentation and two demographic questions on the age and sex of the participant. Each had a unique identifier to enable the evaluator to make comparisons individually. The questionnaires were handed out at the beginning and end of each session in the same manner to everyone who participated.

Results of the project

To determine whether participation in the project changes the participant's answers in a statistically significant way, we gave for each of the nominal variables a choice of answers called optimal, that is, the choice of answers to which the participants should adhere in the post-test. Following the selection of these "optimal" answers, we recoded the multiple level variables into binary variables on the basis of "good" and "bad" answers. The statistical analysis was based on these new variables. The ordinal scale variables and binary variables were analyzed with respect to the three categories of the presentation themes - banking issues, prevention of financial abuse in public places, and prevention of financial abuse at home.

- In total, 176 participants completed one to three questionnaires. Of these, 78% were women and 14.2% were men. 13 respondents (7.4%) did not indicate their sex. Ages ranged from less than 50 years (1.1%) to over 90 years (5.1%). Most participants (64.2%) were between the ages of 70-89 years, which reflects the average ages of persons living in the low-income housing units.
- The majority of participants appreciated the reception they received (100%), the presentations (98.4%), the question and discussion periods (97%) and the environment (94.5%).

- Over 75% of participants stated they learned a lot or a great deal from the sessions.
- The majority of participants (over 90% for each session) would be prepared to recommend the presentations to their friends or neighbors and family members.
- 22-24% stated they knew someone who had been a victim of financial abuse.
- A question regarding the importance of leaving a will showed that the session significantly improved the participant's awareness of the problems that dying without a will could engender on the post-test. Similarly other questions improved, such as how to carry a purse safely at a restaurant or in a grocery store.
- Occasionally, the questionnaires demonstrated that the content of the presentations was not clear enough to ensure participants chose an "optimal" answer on the post-test. An example was the question asking what they would do if someone called and claimed to be a bank employee or if someone knocked on your door. These two questions drew a variety of answers on the post-test.

Limits of the project

Some limits of the project were observed. Not all participants attended all three sessions, which was compensated for as each session was organized as a separate session. Not all the participants at the sessions completed the questionnaire for the following reasons: they arrived late to the session, they left early or they were reluctant to divulge any personal information (even though confidentiality was ensured). In addition, due to literacy, language or vision problems, several did not wish to complete the questionnaires despite the offer of assistance. The analysis also showed that some of the questions might have been ambiguous, lessening the participants' chances of answering correctly.

Overall we can conclude, through the quantitative and qualitative analysis of the results of the study, that the sessions had a positive impact on the participants who had no prior knowledge of the appropriate

behaviors to adopt in the particular situations of potential financial abuse. A high percentage of seniors showed a significant increase of their understanding of which behavior to choose in most situations presented following the presentations. In addition to the formal written questionnaires, verbal feedback from participants was also solicited. The feedback from participants was extremely positive in terms of their comprehension of the presentations, their questions regarding the issues and their comments about how they would act in future potentially abusive situations. They were also pleased to have had the opportunity to interact and converse directly with those responsible for their safety, and felt empowered to make informed decisions, protect themselves and refer, when necessary, to these experts. Some remained behind to discuss their personal experiences with the presenters during the break for the refreshments. Finally we can conclude that crime prevention is difficult to demonstrate in this type of community setting, at least quantitatively. Based on our analysis, though, we can confirm that most of the seniors would modify some of their behavior and actions concerning banking issues, safeguarding their home and walking on the street to ensure the safety of themselves and their property. Some of the feedback was also useful to the presenters to modify the content of their own presentations with future groups of seniors.

Some overall reflections about the prevention of financial/material abuse

We would like to make a few observations following this project, which may be applicable for all communities, worldwide, in the prevention of financial abuse. As societies continue to age with seniors living longer and becoming more vulnerable, there will probably be a greater incidence of financial and material abuse perpetrated against them by persons in a position of trust. The prevention of violence is not the sole responsibility of specialized agencies but a responsibility of whole communities, who can participate in the prevention of such violence by empowering the seniors in the community to protect themselves and by promoting respect among other members of the community. We found the concepts relating to empowerment and community development techniques to be valid and essential. The concept of community participation was essential to building effective

partnerships with other organizations to provide a concerted, standardized approach to information-sharing. By bringing the seniors together in groups, they were aware that they are part of a community and not just isolated, powerless individuals. They participated readily in the group discussions, finding their voices. As well, the project enabled the seniors from a multicultural, urban milieu to be aware of their rights and provided them with the skills, knowledge and choices to assist them in making optimal decisions when confronted by potential abusive situations.

We demonstrated that seniors, though vulnerable because of physical and psychological losses, were able to integrate new knowledge and information by giving them the resources, energy and power to make optimal choices and decisions for their security and safety. Furthermore, the group was enabled through the empowerment process of the project to present a brief to the Ministry of Health and Social Services about their insecure living conditions and ways to improve them. This step is the final phase of the Ninacs(1995) empowerment model entitled "Critical Awareness" in which the person or group becomes aware that they are not the only persons with the problem, but that the individual and collective problems are influenced by the way in which society is organized and that the solution to the collective problems comes through social and political systems. Through social change strategies, they can achieve resolution to their collective problems.

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Protecting Vulnerable Older Adults in the Health Care System

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ABSTRACT

Originally formed in November 1989, the Geriatric/Long Term Care Review Committee to the Chief Coroner for the Province of Ontario has a mandate to improve medical care for the elderly in Ontario and decrease the occurrence of what could be construed as 'medical abuse'. The committee believes in the motto of the chief coroner's office: We speak for the dead to protect the living. The committee conducted an independent review of the available records relevant to the specific case and then prepare a final report including recommendations where indicated, to be sent back to the local community for discussion and implementation with the aim being to prevent future deaths in similar circumstances. Annual reports highlighting systemic concerns are created and distributed widely across Canada. Several cases that highlight common problems in medical care of the elderly were used to illustrate the activities of the committee. The Committee is of the view that systematic review of problem cases in care of the elderly with production and dissemination of annual reports has been an important method for improving the care of the elderly in Ontario and Canada.

Key words : Medical care of the elderly, Medical abuse, Improving care of the elderly.

Originally formed in November 1989, the Geriatric/Long Term Care Review Committee (GLTCRC) has just completed its eighteenth full year of operation. The Committee is an advisory committee to the

* The paper is a retrospective review of the activities of the geriatric / long term care review committee to the chief coroner for the province of Ontario.

Chief Coroner that conducts independent reviews of deaths of elderly persons in both acute care and long term care facilities in Ontario. The Committee is chaired by a Regional Supervising Coroner and includes respected health care professionals including a dietician, family physicians, geriatricians, an emergency room physician, and a local coroner. When indicated (i.e. geriatric psychiatry, gastroenterology, infectious disease) have assisted the Committee with case reviews.

In 2007, cases were referred to the Committee from a variety of sources including local coroners, Regional Supervising Coroners, and the Office of the Chief Coroner. In the previous years, cases had been reviewed at the request of advocacy groups and long term care facilities.

The Committee conducts an independent review of the available records relevant to the specific case and then prepares a final report including recommendations, where indicated, which are forwarded to the local community for discussion and implementation with the aim being to prevent future deaths in similar circumstances.

Originally formed in November 1989, the Geriatric/Long Term Care Review Committee (GLTCRC) has just completed its eighteenth full year of operation. The Committee is an advisory committee to the Chief Coroner that conducts independent reviews of deaths of elderly persons in both acute care and long term care facilities in Ontario. The Committee is chaired by a Regional Supervising Coroner and includes respected health care professionals including a dietician, family physicians, geriatricians, an emergency room physician, and a local coroner. When indicated they (i.e., geriatric psychiatry, gastroenterology, infectious disease) have assisted the Committee with case reviews.

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Committee case review statistics for the last 10 years are included in Table 1:

Year	Number of cases reviewed	Total Number of Deaths	Number of Cluster Investigations with (# of Deaths)
1998	18	18	0
1999	15	15	0
2000	20	25	1 (6)
2001	30	30	0
2002	21	21	0
2003	17	17	0
2004	25	38	Homicide Review
2005	28	28	0
2006	27	27	0
2007	17 (not complete)	17	0

Committee members have participated in the following activities over the years:

1. Regular monthly meetings,
2. Regional Coroners' Reviews,
3. Liased with individuals, government ministries, acute and chronic care, general and psychiatric hospitals, public health departments, long term care institutions, medical and nursing associations, advocacy groups, Ontario and American Coroners and medical examiners, the Chief Coroner of the other Canadian Provinces and Territories, the International Association of Coroners and Medical Examiners and various professional gerontological associations,
4. Published a number of articles in the medical literature, and
5. Provided independent expert evidence at inquests.

The types of recommendations generated for the years 2002 through 2006 are included in Table 2:

	2002	2003	2004	2005	2006
TOTAL NUMBER OF CASES	21	17	25	28	27
MEDICAL/NURSING MANAGEMENT	13(28)	7(16)	14(26)	12(24)	10(30)
COMMUNICATION/ DOCUMENTATION	8(12)	9(10)	9(16)	7(9)	(6)(8)
USE OF DRUGS IN THE ELDERLY	(6)(17)	4(8)	7(10)	5(8)	8(14)
ADMISSION/DISCHARGE/ TRANSFER PROCEDURES	6(10)	4(8)	3(3)	3(4)	3(5)
DETERMINATION OF CAPACITY AND CONSENT FOR TREATMENT/DNR	2(2)	3(4)	2(2)	2(3)	0
USE OF RESTRAINTS	0	0	0	0	1(4)
THE MINISTRY OF HEALTH AND LONG-TERM CARE	0	2(4)	6(10)	1(1)	0
THE ACUTE AND LONG TERM CARE INDUSTRY	0	0	6(12)	6(9)	0
THE OFFICE OF THE CHIEF CORONER	4(4)	8(8)	10(10)	7(9)	9(9)

A number followed by a bracketed number (i.e. 10(30)) indicates that there were 10 cases with a total of 30 recommendations made relevant to the topic area.

As was the case over the previous years, the Committee noted that the "Medical/Nursing Management" section was the number one topic area for recommendations generated over the last five years. The "Use of Drugs in the Elderly" section has now replaced the "Communication/Documentation" section as the number two topic area for recommendations generated in 2006.

In 2006, the Committee reviewed four cases in which no recommendations were generated.

Further analysis of the “Medical/Nursing Management” section revealed a number of common and recurrent themes leading to requests for independent review by the Committee. These themes include the following:

1. Constipation and obstipation,
2. Prevention and management of “bedsores”,
3. The use of diagnostic labels including “cancer” and “ALC” (alternate level of care), and
4. Management of the elderly in the emergency room setting.

Similarly, common and recurrent themes in the “Use of Drugs in the Elderly” section include the following:

1. The use of psychotropic drugs,
2. The use of anticholinergic drugs,
3. The use of narcotics including Meperidine Hydrochloride.

The following 4 case studies are examples of some of the recurring issues being reviewed by the Committee:

CASE # 1

Issue

1. Emergency room management of the elderly,
2. Constipation in the elderly.

History

This is the case of an 89 year old woman who was admitted to a licensed long term care facility (LTCF) from her home on November 23, 2002 at age 86 years. Her past medical history was extensive. In the LTCF, she underwent a number of investigations. She appeared to be doing well until May 17, 2005 when she fell which resulted in fractures of her vertebral spine.

Following the fall on May 17, 2005, the woman initially refused an assessment of her injury. She was assessed in the emergency room (ER) of a general hospital (GH) the following day where investigations revealed the presence of multiple fractures of her vertebral spine. The physician’s section of the ER record included a section for vital signs

which was blank. While the woman’s vital signs may have been recorded in another section of the ER record, the Committee could not determine if the ER physicians were aware of an elevated temperature. In the Committee’s experience, the recording of a patient’s vital signs on the physician’s portion of the ER record would ensure that the physician is aware of any abnormal vital signs. The recognition of the presence of abnormal vital signs would then allow the ER physician to investigate the reason(s) for the abnormal vital signs. Although this did not appear to be a factor in this woman’s death, the ER management of an 89 year old patient with compression fractures may well differ if there is an unrecognized and undiagnosed comorbidity such as a febrile illness. On both ER visits, the woman’s vertebral spine fractures were recognized and she was returned to the LTCF.

Upon her return to the LTCF, the woman’s mobility was limited by the presence of pain. It would have been reasonably anticipated that her fracture related pain would respond to common analgesic medications.¹ Her pain was initially managed by intermittent dosing with short acting Opioids in combination with Acetaminophen.

Codeine containing preparations were discontinued on May 25, 2005 following which her pain was mainly managed with Oxycet. There is evidence in the literature which supports this pharmacologic approach given that 10% of caucasians are unable to convert Codeine to its active metabolites.² Sustained release Opioids were not prescribed and, based on her sporadic and infrequent use of analgesics, the Committee believed that this was a reasonable therapeutic approach. In addition, this was respectful of her often expressed wish not to take medications.

In the elderly, the development of constipation is frequently multifactorial. Some of the known risk factors include the following:

1. The presence of pain,
2. The use of narcotic containing medications to control the pain,
3. The presence of pre-existing large bowel disease,
4. Decreased oral intake,
5. Dehydration,
6. Decreased mobility, and
7. Age (>55 years).

In this particular case, an additional factor may have included a tendency to under-report or minimize symptoms. The woman did self report her bowel movements and was known to refuse initial investigations and medications from time to time.

On May 22, 2005, the woman was started on a 10 day course of a stool softener, Docusate Sodium, which resulted in her passing stool on almost a daily basis until the medication was stopped. Thereafter, her bowel movements were less frequent, generally once every third day. The Opioid medications were stopped altogether on June 26, 2005. Over this time period, prophylactic, sustained laxative therapy was not administered. In the Committee's experience, a regular prophylactic bowel management regimen should almost always be commenced in the elderly when narcotic therapy is initiated for the purpose of minimizing the risk for the development of constipation. This should include such items as patient education, counseling and management of toileting activities, lifestyle factors such as fluid and fibre content, and pharmacologic treatment.³ In this particular case, Lactulose (a laxative) was ordered by the most responsible physician to be given on a "prn" basis if the woman became constipated. Lactulose is an excellent choice for the prevention of opioid-induced constipation.⁴ While the physician did specify the purpose of the Lactulose, the Committee wondered if the medical and nursing health care professionals appreciated that the woman's change in stooling frequency from May to June was an indication that she was becoming constipated. As well LTCF residents are often unable to express their symptoms accurately.

The woman was found sitting in a chair in her room on July 2, 2005 complaining of abdominal pain. The nursing staff noted the presence of a fever. On July 3, 2005, she was found lying in her bed with similar complaints and a fever which resulted in her being transferred to the ER of the GH where she was subsequently admitted.

She was seen in consultation by a surgeon. Following the initiation of antibiotic therapy, she was taken to the operating room where she had an exploratory laparotomy with resection of the rectum, drainage and a colostomy. The surgeon noted the presence of an area of necrosis on the left lateral wall of the mid rectum with a perirectal abscess

cavity which communicated with the rectum. The postoperative diagnosis was a perforated rectum.

The surgical pathology report read as follows:

"Diverticulosis with perforated acute diverticulitis and pericolic abscess formation. Negative for malignancy."

An addendum to the report read as follows:

"The surgeon informed me that the perforation occurs in the mid rectum. There is a large amount of hard stool in the intestinal lumen. Since diverticular disease rarely, if ever, involves the rectum, other causes of rectal perforation have to be entertained. In light of the clinical findings as well as the focal mucosal necrosis adjacent to the perforation, it is likely that stercoral ulceration is the cause of the perforation."

Postoperatively, the woman was admitted to the intensive care unit (ICU) where she was managed with ventilatory care, fluid support, and antibiotics. On July 5, 2005, she was transferred out of the ICU. A clear fluid diet was commenced three days later. By July 15, 2005, the woman was up in a chair and appeared to be improving.

At 1000 hours on July 18, 2005, the woman suddenly became unconscious. Immediate medical assessment was obtained. Her son was present at her bedside and requested no further investigation or treatment. Comfort care measures were instituted. It was the opinion of the treating physician that she had likely suffered a cerebrovascular accident (stroke). 40 minutes later at 1040 hours, death was pronounced. A post mortem examination was not performed.

Recommendations

1. Health care professionals should be reminded that constipation and obstipation are common, preventable, and treatable medical conditions that affect the elderly. Untreated, these conditions can be devastating and may even result in death. Once obstipation is suspected, aggressive investigation and treatment should be considered on a case by case basis.

As with many geriatric syndromes, obstipation may present either typically (abdominal pain, fecal incontinence) or atypically (confusion,

delirium). Health care professionals should be especially wary of elderly patients who have constipation/obstipation or who have associated systemic symptoms (tachycardia, fever). In these cases, the ordering of laboratory investigations and an EKG should be considered on a case by case basis.

The occurrence of overflow incontinence should alert the treating health care professionals to the possibility that the patient has developed fecal impaction with overflow incontinence. Fecal impaction can be difficult to treat and should be treated vigorously when present. Careful abdominal and rectal examinations should be performed. The findings of soft stool or no stool in the rectum does not absolutely rule out the presence of fecal impaction.

In these cases, an abdominal flat plate x-ray and/or a CT scan should be ordered to rule out the possibility of a higher impaction that cannot be detected on rectal examination and/or a developing acute/subacute bowel obstruction (dilated loops of bowel with air/fluid levels). While manual disimpaction should be the first intervention attempted, the presence of obstipation with a higher impaction should primarily be managed with enemas to clear the bowel from below. In some cases, the addition of oral osmotic laxatives such as Lactulose can be used to clear the bowel from above. Gastrointestinal lavage solutions have also been proven to be very effective in treating fecal impaction.

Health care professionals should always be observant for the development of complications and especially for the development of complications related to the treatment of obstipation/fecal impaction.

Reference: Constipation Can Be Deadly – Canadian Family Physician Volume 38, October 1992, Goldlist, B., Naglie G., Gordon M.

2. Health care professionals should be reminded of the importance of instituting a regular prophylactic bowel regimen at the initiation of opioid therapy for the purpose of preventing the development of constipation.

Components of the regimen should include:

- a) patient education,
- b) counseling and management of toileting activities,
- c) lifestyle factors such as the diet including fluid and fibre content, and

d) pharmacologic treatment.

Reference: Folden SL, Practice guidelines for the management of constipation in adults, Association of Rehabilitation Nurses; 2002. 51 p.

3. Health care professionals caring for the elderly in both acute and long term care facilities should receive ongoing training in:

- a) the definition of constipation in adults,
- b) the clinical conditions and pharmacologic interventions that may put the patient at risk to develop constipation and
- c) strategies which will allow for the early recognition of constipation.

CASE # 2

Issue

1. The use of narcotic analgesia in the elderly.

History:

This is the case of an 82 year old man who was admitted to a LTCF for respite care on October 19, 2005. Within 3 days, his admission status was changed to permanent and within 10 days, he was dead. Death was attributed to an acute thrombotic occlusion of the circumflex coronary artery in association with acute Fentanyl intoxication.

On transfer to the LTCF, the man was noted to be quite confused and had “depression at separation.” In the Committee’s experience, it is not unusual for newly admitted residents to a LTCF to exhibit confusion especially if the resident has cognitive impairment which was likely the case in this instance. Of some concern to the Committee was the fact that an antidepressant was prescribed during a period of transition and without definitive evidence of the presence of a major depression such as a high score on a standardized assessment tool such as the Geriatric Depression Scale or criteria to support a DSM IV diagnosis. In the Committee’s opinion, the prescribing of an antidepressant was not a factor in the gentleman’s death.

Of major concern to the Committee was the fact that the man was diagnosed as having chronic pain while the medical record suggested that the pain was of recent (3 day) onset. From the documentation submitted for review, no examinations or investigations were done in an attempt to detect the cause of the pain. A Fentanyl Patch was

prescribed as the initial therapy despite the fact that the United States FDA Approval Label for transdermal Fentanyl emphasizes that the medication is for the use in opioid tolerant patients only. The Label goes on to note that serious life threatening hypoventilation can occur in patients who are not opioid tolerant. Given the gentleman's rapid decline following the application of the transdermal Fentanyl Patch, the Committee suspected that the medication may have contributed to the death.

Recommendations

1. Health care professionals should be reminded of the importance of using caution when making the diagnosis of depression in a resident newly admitted to a licensed long term care home. Recognized valid diagnostic criteria should be used to make the diagnosis of depression.

Reference: National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (focus on mood and behaviour Symptoms)

Conn D, Gibson M, et al, Canadian Coalition for Seniors' Mental Health, 2006.

Available through the website: www.ccsmh.ca

2. Health care professionals caring for the elderly in the long term care setting should be reminded that the first step in management of any painful condition should be an attempt to identify the cause of the pain.
3. Health care professionals should be reminded that the Fentanyl transderman patch should only be prescribed to opioid tolerant patients. If a patient develops side effects such as unresponsiveness or a decreased level of consciousness, the patch should be removed immediately and consideration should be given to the use of a narcotic antagonist.

CASE # 3

Issue

1. Emergency room management of the elderly.

History

This is the case of a 70 year old woman who underwent a bowel resection with a colostomy in July 2005 for cancer of the rectum (colon). She completed a course of chemotherapy on November 15, 2005, 12 days prior to her first ER visit on November 27, 2005, and was scheduled for radiation on December 5, 2005, the date of her death.

At 0155 hours on November 27, 2005, the woman first presented to the ER of the small local community GH with back pain, constipation, and had not recently urinated. There appeared to be some confusion as to the time of her initial assessment by physician "A" given the times recorded on the ER Record. The time of assessment on the ER Record was recorded at 0730 hours when the woman had arrived at 0155 hours, had been registered at 0209 hours, and according to the nursing notes, was awaiting reassessment at 0715 hours with 2 enemas and Lactulose having been given prior to 0730 hours. If the woman had been assessed by physician "A" prior to 0730 hours, the Committee was confused by the apparent focus on her constipation and not on the back pain which was her chief complaint. Orders for pain control were not recorded until after 0730 hours. An order for Tromethamine 60 mg. IV was written but this was corrected to 30 mg. When her care was transferred to physician "B" as evidenced by the presence of discharge type prescriptions on the medical record, it would appear that physician "A" was planning to discharge the woman home. Eventually, admission was arranged under physician "C". The woman was appropriately investigated and managed in the GH which resulted in her being discharged on December 1, 2005 with improved pain control, improved bowel function, and no shortness of breath.

Three days later at 0830 hours on December 4, 2005, the woman returned to the ER complaining of increased back pain which had suddenly occurred during the night. The woman was seen by physician "D" who did not document a thorough examination. Notation was made however, that her blood was "OK" and there was no xray evidence of a fracture. The decision was made to discharge her home with instructions to increase the amount of long acting Morphine Sulfate by altering the time interval between doses from 12 hours to 6 hours (bid. to qid. dosing).

Based on a review of the woman's ER record, the Committee was concerned with how she was assessed and managed on this visit. The Committee's concerns included the following:

1. When compared to her previous visit to the ER on November 27, 2005, her vital signs had changed significantly and were abnormal. Her respiratory rate (RR) had increased from 18 to 28. Her blood pressure (BP - 155/107) and pulse (P -123 and irregular) were elevated on the prior visit possibly due to the presence of pain. On the present visit, her BP had decreased to 90/60 and her P had decreased to 107. Was consideration given as to why her vital signs had changed and perhaps more importantly, why her BP dropped when she was complaining of increased back pain?
2. Her liver function tests were now elevated and abnormal on the visit of December 4, 2005. Was consideration given as to why the liver function tests had changed?
3. Her renal function tests were now elevated and abnormal to a significant degree given the short time interval between testing. Was consideration given as to why the renal function test had changed?
4. The woman's neutrophil count was now elevated. Given the history of recent chemotherapy and the previous low neutrophil count of 0.2 recorded just 3 days earlier on December 1, 2005, was consideration given as to why her neutrophil count had changed?
5. There was xray evidence of the presence of a new pulmonary infiltrate. Was consideration given as to the significance of this new chest xray finding?
6. There was xray evidence that the compression fracture of L1 had progressed from an end plate fracture to a 50% loss of vertebral height which was the probably cause of her increased back pain. Was consideration given as to the significance of this interval change?
7. Why was the long acting Morphine Sulfate ordered at qid. interval rather than at a bid. interval, the interval at which it is intended to be given?

8. Did the treating health care professionals realize the impact that impaired hepatic and renal function would have on this long acting medication?
9. Given the woman's pneumonia as evidenced by the presence of chest xray evidence of a new pulmonary infiltrate and her chronic obstructive pulmonary disease (emphysema), did the treating health care professionals realize the increased potential for this long acting medication to depress respiration?
10. Given the woman's altered clinical condition on December 4, 2005 as compared to her status just a few days earlier, why was consideration not given to re-admitting her to hospital for investigation and treatment?
11. Did the treating health care professional realize that the standard practice to manage pain is to incrementally increase the dosage of short acting analgesics?

The pathologist concluded that the cause of death was consistent with acute morphine intoxication in association with small bowel ischemia and acute bronchopneumonia status post recent colectomy for colonic carcinoma.

The Committee noted that the woman had not been designated as "palliative", did not have a "DNR" (Do Not Resuscitate) order, and had no evidence of recurrent/metastatic cancer. Although there was no documentation on the ER record for the visit of December 4, 2005 to suggest that the woman was terminally ill with cancer, the Committee wondered if the fact that the woman was known to have "cancer" negatively impacted in the health care she received on this visit.

Recommendations

1. Health care professionals working in the emergency room setting should be reminded of the importance of reviewing the results of laboratory and imaging clinical parameters such as vital signs, laboratory, and imaging procedures conducted on elderly patients who present themselves to the emergency room on more than one occasion during the course of an illness. The comparing of results recorded on the present visit with those recorded on previous visits

may be invaluable in accurately assessing the elderly patient's clinical condition and the reason for the present visit. Documentation of the entire process on the emergency room health care record should be mandatory.

2. Health care professionals working in the emergency room setting should be reminded of the importance of obtaining an appropriate history, conducting a thorough examination, and judiciously utilizing available laboratory and imaging resources on elderly patients who present new or changing symptoms.
3. Health care professionals and especially health care professionals working in the emergency room setting should be reminded of the importance of not being negatively influenced by the fact that an elderly patient is "old" or has a diagnostic label such as "cancer."
4. Health care professionals and especially health care professionals working in the emergency room setting should be reminded of the importance of having a full understanding of the pharmacokinetics of narcotics prescribed to control pain.

For example, the lowest possible dose of short acting narcotics such as Morphine Sulfate should be the initial dose with increasing doses titrated upwards depending on the patient's clinical response.

The use of long acting narcotics may also be of benefit but their dosage and timing between doses must be carefully monitored and in keeping with recognized medical practice.

5. Health care professionals should be reminded of the importance of watching for the development of side effects of medications prescribed for elderly patients with impaired hepatic or renal function.

Conclusions

While the Committee reviews individual cases and prepares a report with recommendations specific to the circumstances surrounding the death, it is the Committee's Annual Reports that have been instrumental in the education of health care professionals in an effort to improve care of the elderly in the Province of Ontario and throughout Canada.

The Committee believes their work strongly supports the motto of the Office of the Chief Coroner.

"We speak for the dead to protect the living."

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Adult Protection Legislation : From Intent to Practice in Three Canadian Provinces

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ABSTRACT

Acknowledgement of the mistreatment and neglect of older people has led to searches for ways to address these phenomena. Adult Protection legislation is one mechanism for response by governments. This paper reports on the accumulated findings of three sequential studies investigating the relationship between legislated provisions, formalized social welfare services, and locally generated responses intended to alleviate the mistreatment and neglect of older people. The research was undertaken in three rural communities in Canadian Provincial jurisdictions where Adult Protection legislation has been in use for over twenty years. Findings indicate that there is a complex relationship between the provisions of Adult Protection legislation and the provision of assistance, and that there are considerable issues with regard to respecting the rights and autonomy of older people.

Key Words : Mistreatment, Neglect, Adult Protection Legislation, Social welfare Services, Rights of older people.

Adult protection legislation is one response to what is frequently referred to as problem of "elder abuse and neglect" which, until recently, has for the most part been characterized in Western states as one type of "family violence" (Straka & Montminy, 2006). The individual provinces and territories that make up the Canadian Federation hold legal jurisdiction over matters pertaining to family life. As a consequence there is no Federal Adult Protection legislation. However, a number of

the provinces and territories have passed legislation dealing with the protection of vulnerable adults who are mentally incapacitated. This paper refers to research carried out in Canada's three Maritime Provinces each of which has similar longstanding legislation targeted at adults seen to be in need of protection.

The Social and Historical Context for the Development of Adult Protection Legislation

It has been argued in both North America and Europe that the reasons for the particular trajectory of "elder abuse and neglect" and its evolution as a social problem lie in its social context (Baumann, 1989; Kosberg et al., 2003; Leroux & Petrunik, 1990; Chappell et al., 2003; Ogg & Munn-Giddings, 1993). In the 1950s, in both North America and Europe there was an overabundance of workers at the same time as employers wanted to renew their labour force in response to new technologies and new needs (Anetzberger, 2005; Townsend, 1986). This resulted in policies that forced older people to retire. The state pensions that accompanied these retirements changed their status from that of paid worker to recipients and dependents of state support.

A theory of aging that viewed old age as a gradual disengagement from life (Cumming & Henry, 1961), with retirement as the major step in this disengagement, emerged fortuitously at the same time as the labour market policies described above; indeed "Cumming and Henry argue that aging cannot be understood separate from the characteristics of the social system in which it is experienced" (Lynott & Lynott, 1996). The Disengagement theory was, from its beginnings, the subject of criticism and dispute among scholars. However, despite this, in Western societies disengagement theory appears to have had a powerful, and continuing, effect on societal perceptions of older people (Lynott & Lynott, 1996), so that in some areas of social life, older adults are expected to withdraw. Indeed, some contemporary sociologists still argue that older adults who are active are refusing to acknowledge the aging process.

In company with most other Western societies Canada has an aging population so that the numbers of older people in society are increasing relative to those of other age groups (Gee & Gutman, 2000). In Canada a large proportion live with their spouses or, especially in the

case of women who have a greater life span than men, live alone. However, this pattern may vary according to family history and cultural values, especially among immigrants and aboriginal peoples. Despite the fact that most older people are relatively healthy and require little care Anetzberger (2005) points to a concern by professionals from the 1950s on “that the growing number of mentally impaired older people living alone ... could not provide for their own care and protection without community intervention” (p. 2).

Thus the concept of “elder abuse and neglect”, and responses to it were developed in an era when older people were identified as a homogenous group based on chronological age, and were marginalized by an understanding of their capacities that was associated with their exclusion from the labour market and with a perception that their roles in society were limited and subject to decline. (Neugarten, 1967).

Baumann (1989) argues unequivocally that “elder abuse and neglect” was socially constructed by professional “experts” as part of the development of gerontology as a discipline. Baumann’s perspective is coincident with that of Leroux and Petrunik, for whom the idea of “elder abuse” as a social problem emerged from “the public perception of old age as a social problem”, where “old age overrides all other statuses and has the most priority in the characterization of the individual”. Based on the perception of old people as frail in mind and body there is “an assumed need to protect the elderly” through professional intervention. Moreover this construction “overrides their status as legally and socially competent adults” (1990, p. 653).

This construction of old people is central to issues arising out of the Adult Protection legislation that has been widely used in North America as a response to the mistreatment and neglect of older people. For instance in the United States each state has Adult Protection legislation. In Canada, as a consequence of constitutional arrangements formal responses to incidences of mistreatment and neglect, whether based on legislation or programs, are unique to each province. The Atlantic model is one of three intrinsic models (Gordon, 2001). This model pertains to each of the three Maritime Provinces included in our discussion. It includes “special adult protection legislation” and has been characterized as similar to the legislation addressing child abuse

in that “upon receiving information that an adult is being neglected or abused adult protection service personnel will investigate the case” (Gordon, 2001, p.119). Concerns have been raised about the extent to which such legislation fosters an ageist perception of older people as vulnerable children rather than as adults with their associated rights.

However, in each Maritime jurisdiction, if, after an investigation by an adult protection worker, the older person is found to be legally mentally competent, they are free to refuse assistance and to choose to remain in a situation which others consider to be not in their “best interests”. It is noteworthy that many older people do refuse assistance and that this causes considerable frustration among those who seek to offer help (Barer, 1997). Each of the three studies carried out by members of our research team, and discussed below, has shed some light on just how difficult and complex it is to use legislative provisions to facilitate assistance to mistreated and neglected older people.

Methods

All three studies have used a combination of qualitative methods including: 1) a broad based review of the literature relating to elder abuse and neglect and its contextualization within the field of aging; 2) a comprehensive review of the legislation and legal articles relating to elder abuse and neglect; 3) interviews and focus groups with participants representative of a wide range of formal and informal providers of assistance including adult protection workers; health and social service professionals, police and police safety officers, professional and lay members of non-profit organizations such as women’s shelters, the Victorian Order of Nurses and Meals on Wheels, faith leaders, members of seniors' organizations, volunteers and interested individuals, with the addition of members of the judiciary for the first study; 4) telephone and face to face consultations with a number of key service providers, advocates and policy experts (Harbison *et al.*, 1995; Harbison *et al.*, 2005).

In the first study (Harbison *et al.*, 1995) the interview data was subjected to content analysis including initial coding by the interdisciplinary team. The second and third studies employed “the constant comparative method of data analysis ... including ongoing coding and analysis by the research team” (Harbison *et al.*, 2005,

p.236). In all three studies dissemination groups are an integral part of the qualitative methods affording an opportunity both to discuss and amend the findings with our participants.

The Geographic Context

Each of the three Provinces under consideration have relatively small populations even within the Canadian context. Nova Scotia has a population of approximately 900,000, New Brunswick 750,000 and Prince Edward Island 135,000. The inhabitants are chiefly white and European immigrants of longstanding, as well as small numbers of indigenous First Nations peoples and African Canadians who have been residents for over two hundred years. We drew the participants for our studies from both urban and rural locations and from those areas that were relatively wealthy and those that were relatively poor.

Findings

Our first study of Adult Protection legislation was requested in 1992 by the Nova Scotia Government's Department of Community Services. Our research team was asked to explore the reasons for a great deal of dissatisfaction directed at Nova Scotia's *Adult Protection Act* which had been proclaimed in 1986. We found that criticisms came from the judiciary because the implementation of the legislation raised issues of individual rights. For instance *The Canadian Charter of Rights and Freedoms* (1982) guarantees equality rights for all Canadians with no discrimination on the basis of age. Judges were concerned that some cases being investigated and brought before them did not fully consider these rights. On the other hand many professionals and lay people looked to the Act to solve the problem of older people in living situations that did not meet community norms and standards. Many of these mistreated, neglected and/or self neglecting old people were refusing assistance to change their living conditions, and because they were mentally competent were legally entitled to do so. There was a further reason for referral to Adult Protection Services even where the referee knew that the person was mentally competent and did not fall under the provisions of the Act. That was the hope that such a referral might lead to the provision of much needed services for their clients - services that would not otherwise be supplied because they were in such short supply.

Thus Adult Protection services had become a magnet for frustrated helpers, legislation of which the Minister said in 1986 "[it] will, presumably, not require frequent application" (The Honourable Edmund Morris, cited in Coughlan *et al.*, 1995, p. 45), by the year 1992-3 dealt with 931 cases - the majority involving older people, 141 of which involved court applications.

Our second study was begun six years after the first study in 2001 and completed in 2004. Given that our earlier study demonstrated the limited capacity of the Adult Protection Act to deal with the majority of problems involving mistreatment and neglect we wanted to explore what was happening informally to address the mistreatment and neglect of older people, as opposed to focusing on the formal services based on provisions of the Adult Protection Act. We focused our attention on rural areas because comments by participants in our previous study indicated that rural areas were especially poor in service provision and that lack of transportation increased the rural isolation of older people.

Our findings suggest that in the intervening period from our earlier study a greater understanding of the limitations of the provisions of the Adult Protection Act had developed. The following remarks made by professionals demonstrate this clearly and are typical of what we heard:

...their [Adult Protection] mandates are pretty narrow. Adult Protection has to have just cause...They'd have to talk to collateral supports a mile long to get justification to go out because the law says they can't intrude until they have just cause.

and the following

[the adult protection worker] came in and the thing that he said was, "I'm not the lifestyle police" and it's a great, really great way to characterize Adult Protection.

This clear understanding of the limitations of the Adult Protection legislation and the rights of older people may well be related to efforts within the departments responsible for Adult Protection Services. For instance, the *Adult Protection Services Policy Manual* (April 1, 2001) refers to their mandate to provide "services to protect vulnerable adults while respecting the inherent rights of adults to live their lives according to their own beliefs and wishes" (p. 1) and, "[recognizes that] all

adults have the right to autonomy and self-determination” (p. 2) [and to] the ability to enjoy the fundamental rights and freedoms prescribed in the *Canadian Charter of Rights and Freedoms* (p. 3).

However, while on the one hand we found this clear understanding of the limitations of the adult protection role under the Act, on the other we found a greatly enhanced role for adult protection workers. Among health and social service professionals they were valued for their expertise in understanding abuse, neglect and self neglect and in finding ways to address it. Inexperienced health and social service workers relied a great deal on consultation from an adult protection worker “...most cases I usually would call Adult Protection and brainstorm with them” (social worker).

Nevertheless, referrals to Adult Protection were not always benign. As in the previous study it was suggested that “pressure from the community ... that people aren’t making safe choices” led some workers to make a formal referral to Adult Protection services even when they knew the situation would not meet the criteria of the Adult Protection Act “... and then [he or she] will go back to the community and say, you know, it’s, been referred but at this point they have the right to risk” (statement of home care coordinator). This is an ethically and legally disturbing use of the provisions of the Act, whereby older people’s rights are knowingly infringed in order to give primacy to community values and protect the professional reputation of the worker involved.

In contrast, we also found considerable cooperation between many differing groups and individuals seeking to provide assistance that was acceptable to the older person without using a formal referral to Adult Protection. In addition to formal health and social service providers, police, faith leaders, meals on wheels organizers, members of seniors’ organizations and interested individuals on occasion combined their efforts to provide help. We heard about many instances when community members came together to generate creative solutions to meet the needs and of wishes older people in a range of difficult and bad circumstances. It appeared as if over time people had become reconciled to the limitations inherent in Adult Protection legislation and had been able find other ways to assist the older members of their communities. Once again, however, many people commented on the

lack of services to support older people, especially those living in their own homes. Moreover the only alternative residential accommodation was long term residential care, often far from the person’s community. This alternative was one that most older people refused to contemplate.

The third study referred to in this discussion is currently under way. The choice of the Maritime Provinces was based on the parallel provisions of the legislation in each province in that they followed a “child protection” model (Gordon, 2001, McDonald *et al.*, 1991). The study is aimed at exploring the extent to which the differing provisions of Maritime adult protection legislation may lead to differing patterns and practices in what assistance is provided and how. Our interest in pursuing these questions emerged from the findings of the second study discussed above. This, as we have seen, suggested that in Nova Scotia a wide range of professionals and community members came together to address their concerns about diverse manifestations of what has come to be known as “elder abuse and neglect”, and in doing so transcended the provisions of the Adult Protection Act. Finally, we want to understand whether there are adequate services to assist in resolving older people’s situations of mistreatment and neglect.

While our analysis is as yet incomplete one important finding has emerged so far. The comparative study has highlighted a current preoccupation among professionals in all three jurisdictions with whether or not a person is “mentally competent” and therefore has the right to live at risk. The quotations below illustrate this. A mental health worker says:

One of the biggest challenges is knowing what we can actually do and what we can’t...and we need to know when to stop. And those are all... frankly stressful kinds of judgment calls that we have to make with high case loads.

An Adult Protection worker says:

So if it’s a competent person and their living situation is terrible, and they refuse medical treatment, they refuse services and they’re competent, then we can’t do anything legally.

And acknowledges that this is:

... a very difficult thing for me when they’ve been declared competent but yet go back to living at risk. And you know everybody’s hands are kind of tied at that point.

The following statement from a social worker sums up many of the issues that attend working with older people:

...from my point of view the number one issue ... legally, is competency. If that person is competent, they are deemed to have the right to live at risk. So competency is a big issue and that's something that we take great pains with ...Some of the bigger issues are the right to live at risk and we all live at risk... We all accept the risks we choose to and some people have lived with a high degree of risk all their lives and just because they're older now doesn't mean that we can say "you don't have a right to do that any more" based on competency.

This social worker recognizes that just because someone is chronologically older does not mean that their right to live the way they choose should be taken from them. However, it is clear that for many people this acknowledgement of rights is not an easy one and that it is tempered by an ongoing pressure to monitor an older person who is perceived as vulnerable. The words of another adult protection worker reflect this:

Oh yes, and often I feel like part of my job is to be a vulture, you know, I just kind of sit and hover over the body, waiting...like, because we are waiting for something to happen. We're waiting for the person to fall ...so you're going and you're just monitoring and you're trying to build a relationship and you're trying to get the person to accept some services...

This worker may also have captured a key element in just why some older people are so reluctant to engage with formal service providers offering assistance – they anticipate the monitoring that may end in the removal of their rights and their autonomy.

Limitations of the Studies

All of the studies used the qualitative methods that are best suited to the exploration of complex topics without a well researched knowledge base. Our chief purposes have been the carefully constructed collection of data that will allow us to understand what the issues are and what questions need to be explored with regard to assisting mistreated and neglected older people. The knowledge accumulated from these three sequential studies has given some direction in our findings. At the

same time we need "...to be careful not to over-interpret their meaning. This is especially so in attempting to apply the findings outside of their immediate cultural and geographic context [and historical timeframe]" (Harbison et al., 2005, p. 242).

Discussion

Adult Protection legislation in the Maritime Provinces was originally conceived as a means of addressing severe situations of mistreatment and neglect by caregivers of vulnerable mentally incompetent old people - a group that constitutes only a small minority of the old. The legislation was not intended to address the self-neglect which constitutes the majority of referrals under the legislation. Nor was it intended to address financial exploitation now widely acknowledged as the most frequent type of abuse, nor a range of mistreatment perpetrated by family, caregivers, acquaintances and strangers and tolerated by older people for their own reasons. Moreover these situations could be dealt with by the provision of more services and increased use of other existing legislation including the Criminal Code (Coughlan *et al.*, 1995; National Seniors Council, 2007). A recent report by the National Seniors Council commissioned by the Federal government concluded that "it is important to recognize that legal solutions alone are not as effective in combating elder abuse as social solutions that include the legal community (2007, p. 12).

However, the very existence of the legislation has, as we have seen, made it the focus of those seeking help for older people experiencing a range of problems. This has the effect of drawing energy away from the provision of assistance to older people to help them solve their problems. Instead that energy that goes into monitoring whether the older person has the mental capacity to make their own decision to live at risk (Webb, 2006). These practices raise profound questions about the extent to which individual rights and wishes should be paramount in our society, whether older people should be treated as full citizens, or whether the needs of family, community and state to "protect" should predominate.

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Elder Abuse and Mistreatment: A Life Span and Cultural Context

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ABSTRACT

Elder abuse is now recognized as a global social and public health problem threatening older people. Older adults, especially the oldest old, are the fastest growing segment of the population in the United States and many other nations. While increased longevity is generally heralded as a positive development, older adults and family members responsible for their care are often faced with associated problems due, e.g., to chronic illness, family mobility, shrinking public and medical resources. Such factors strain families' ability to provide optimal care and increase the likelihood of elder abuse. The violation of a trust relationship, a defining feature of elder mistreatment, suggests that a consideration of social relations across the life span is useful for understanding elder mistreatment. Cultural expectations of intergenerational responsibility and assistance also influence perceptions of and responses to elder mistreatment. This article examines social relations and culture as essential to a comprehensive understanding of elder mistreatment. Such understanding is critical to identifying the risk, improving early detection, and providing sensitive intervention for elders in communities with increasingly diverse populations.

Keywords: Cultural context, Elder abuse and mistreatment, Life span perspective, Social relations

Elder abuse is now recognized as a global social and public health problem threatening older people (Lachs & Pillemer, 2004; WHO, 2002). Older adults constitute the fastest growing segment of the population in the United States and many nations. Demographic projections indicate that there will be 18.2 million adults over the age of 85, or 'oldest old,' in the United States by 2050 (Population Resource Center, 2006). Poverty and disability rates also rise dramatically with age, with disproportionate impact on minority elderly populations and women. It is predicted that rates of dementia, with its attendant needs for long-term family caregiving, will triple in the coming decades (Paveza, Cohen, & Eisdorfer *et al.*, 1992; Pillemer & Suito, 1992; Dyer, Pavlik, Murphy & Hyman, 2002). Given that two-thirds of the aging world population lives in the rapidly changing developing world (United Nations Population Report, 2007), the World Health Organization and the United Nations have called for an urgent consideration of how these trends may contribute to increasing elder mistreatment risk and incidence in the coming decade so as to improve early detection and facilitate sensitive intervention.

In this paper we consider current cultural understandings of elder abuse from a social relations perspective. Guided by the Convoy Model of social relations (Antonucci, 2001; Kahn & Antonucci, 1980), which incorporates a contextual, life span perspective, we examine how cultural expectations of social roles and support of the elderly may contribute to or ameliorate the risks of elder mistreatment.

Evolving Definitions of Elder Abuse

There is no agreed-upon universal definition of elder abuse (Bennett & Kingston, 1993; Wolf & Pillemer, 1989). Generally, elder abuse is understood to include actions of violence or mistreatment committed intentionally or unintentionally, through over abuse or through forms of neglect (Hudson, 1999b). Working definitions also describe types of abuse (e.g., physical, psychological, financial, sexual and neglect), the victim and perpetrator, and the location of abuse (e.g., violence at home or in an institutional setting).

Evolving definitions of elder abuse necessarily reflect the cultural contexts in which they emerge. The World Health Organization and the International network for the Prevention of Elder Abuse defined

elder abuse in the mid-1990s as : "... 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" (Action on Elder Abuse, 1995). In the United States, the National Research Council (2002) adopted their own definition of elder abuse to include "intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm" (p. 40). The NRC version emphasizes the notion of the vulnerability of the elder victim, but specifically omits financial exploitation as well as self-neglect, which may represent as much as 60% of cases reported to social services charged with the protection of adults in the United States (Duke, 1996). In addition, this definition includes the notion that actions contributing to heightened risk can also be construed as elder abuse and mistreatment.

The violation of a "trust relationship" is explicitly identified as a defining feature of elder mistreatment (NRC, 2002), and distinguishes mistreatment from other forms of violence or illegal behavior toward older adults. Trust relationships include "those people who have assumed the responsibility for caregiving or are expected to do so" (p. 41). In most cases, influential trust relationships and their intergenerational dynamics are long-term in nature, and are, therefore, best understood from a life course perspective.

These definitions reflect the values and sensibility of most western social and legal understandings of elder abuse. As such, they provide useful guides for future interventions in the United States and other countries that ascribe to similar value traditions. Nonetheless, culturally specific interpretations of elder abuse are bound to vary between and within distinct groups, (e.g., ethnic, racial, religious) and/or generations. Broad popular engagement in the process of identifying and defining such a complex phenomenon as elder abuse is needed to assure that the legal and programmatic responses based on those definitions, are not "ethically and pragmatically insensitive to the public they are intended to serve" (Hudson & Carlson, 1999, p. 57). It remains critical, therefore, to identify and account for culturally specific conceptions of elder abuse

and mistreatment in increasingly diverse societies around the world (Kosberg, Lowenstein, Garcia, & Biggs, 2003).

Elder Mistreatment: A Global Public Health Concern

Estimates of reported elder abuse in the population range from 2 to 10% (Lachs & Pillemer 2004) and are based on the few extant large-scale probability non-clinical sample surveys in Boston, MA, (Pillemer & Finkelhor, 1988), Canada (Podneiks, 1992), the Netherlands (Comijs, Penninx, Knipscheer, & van Tilberg, 1999), and Finland (Kivela, Kongas-Saviaro, Kesti, Pahkala, & Ijas, 1992).

In Sweden, however, national estimates of elder abuse indicate that 13% of men and 16% of women over 65 years report experiencing some form of abuse (Eriksson, 2001). In spite of minimal societal recognition of elder abuse, a recent Chinese study of elders at large urban health centers found that over 35% of elders reported being mistreated or abused (Dong, Simon, & Gorbien, 2007). Similar concerns of increased elder abuse and neglect have been voiced in India, where a growing percent of the total population is elderly and two-thirds of older people live in rural villages far from medical or social services (Jamuna, 2003). In a recent nationally representative self-report study of Jewish and Arab Israeli elders, over 18% of elders indicated that they had experienced at least one form of abuse (Eisikovitz, Winterstein, & Lowenstein, 2005). Verbal abuse was the most common type of mistreatment, followed by neglect of primary needs. A separate Israeli study found that while 6% of the elder respondents disclosed being abused, 21% were described by medical staff as showing clear evidence of abuse, and 33% were deemed to be at high risk of abuse (Cohen, Levin, Gagin, & Friedman, 2007). This same study found that certain abuse types (i.e., physical, sexual) were more likely to result in disclosure, adding yet another layer of complexity to establishing reliable or comparable prevalence rates.

Effects of Abuse on Morbidity and Mortality

The paucity of reliable global prevalence levels of elder abuse is particularly serious given that the psychological and physical costs to victims can be enormous. Given that elder mistreatment victims are often frail, the injuries from physical abuse or neglect often have severe or long-lasting impact. In a recent longitudinal study of older adults,

elder mistreatment victims were found to be over three times more likely to die during a three year period than non-victims, and this trend became more striking over the full 13 years of the study (Lachs, Williams, O'Brian, Pillemer, & Charlson, 1998). Studies to date have documented that victims of elder mistreatment have significantly higher levels of psychological distress, and more negative self-perceptions in areas of mastery and self-efficacy than non-victims (Comijs, Penninx, Knipscheer, & van Tilberg, 1999).

Methodological Issues

While these studies have shaped the field, findings have been limited by variations in definitional and inclusion criteria that inevitably lower participation by the most vulnerable, such as the frail or cognitively impaired, who are potentially the most likely victims of elder abuse. Overall, experts suspect that problems of elder mistreatment are far more pervasive than currently recognized (Wolf, 2000).

The intrinsic difficulty of accessing vulnerable adults is a substantial hurdle in the field. This concern prompted the United States Congress to call for an American national one year incidence study. That study, conducted by the National Center on Elder Abuse (1998), found nearly 500,000 community-dwelling Americans aged 60 and older were abused, neglected, or exploited. This same study, however, suggested that for every one case reported to Adult Protective Services, at least five additional cases are unreported to social services. Similarly, a separate prevalence study of domestic elder abuse indicated that only 1 in 14 incidents, excluding cases of self-neglect, come to the attention of authorities (Pillemer & Finkelhor, 1988). Rates of underreporting of financial exploitation are assumed to be much higher (Wasik, 2000).

Adaptation of the Convoy of Social Relations: The Case of Elder Abuse

A growing body of research using the Convoy Model of social relations (Kahn & Antonucci, 1980; Antonucci, 2001; Akiyama, Antonucci, Takahashi, & Langfahl, 2003) has demonstrated how personal and situational factors affect the structure of one's support network as well as types of support exchanged and perceptions of satisfaction with that support.

Close, trusting and supportive relationships have been shown to be protective in adulthood and old age against a large array of physical and mental illnesses, such as cardiovascular disease and cancer, depression, certain cognitive impairment outcomes and Alzheimer's disease (Antonucci, Fuhrer & Dartigues, 1997; Fratiglioni, Wang, Ericsson, Maytan & Winblad, 2000; Ingersoll-Dayton, Morgan & Antonucci, 1997; see Bowling & Grundy, 1998 for a recent review), and stress-related health disparities (Antonucci, *et al.*, 2003; Jackson, Williams & Torres, 2003; Vaillant, Meyer, Mukamal, & Soldz, 1998).

At the same time, however, close relations have also been documented as the most common sources of negativity, frustration, conflict, guilt, and ambivalence (Birditt Jackey, Iglesias, & Antonucci, 2007; Luescher & Pillemer, 1998; Murphy *et al.*, 1997; Sutor, Pillemer, Keeton & Robison, 1995). Negative exchanges with close network members have been shown to be more strongly or reliably associated with health outcomes than positive relationship quality (Kiecolt-Glaser, *et al.*, 1993; Rook, 1997). In fact, extreme cases of negative relationships may deteriorate into violent, neglectful or exploitative interactions.

Such complex dynamics and outcomes of close social relations and support across the life span have been increasingly considered within a cultural context (Akiyama *et al.*, 2003; Antonucci & Jackson, 2003; Elder, 1998, 2002; van Tilburg, *et al.*, 1998). With respect to the complex phenomenon of elder abuse, we consider several macro-level influences, such as cultural values, gender norms, as well as ongoing societal changes that inevitably impact social relations and elder care. We also consider how personal and situational factors, such as gender, health status, and relationship, may influence relationships and the potential for abuse.

Cultural Expectations as Context for Abuse

Despite globalization, distinct cultural value systems, religious orientations and expectations towards older adults shape attitudes towards elder abuse in different parts of the world (Inglehart & Welzel, 2005). Cross-cultural theorists have indicated that cultures vary on several value dimensions, including individualism/collectivism, relatedness/ separateness, traditional/secular, and self expression/survival and modernism/postmodernism (Hofstede, 1980; Inglehart & Welzel, 2005; Markus & Kitayama, 1991).

Using the World Values Survey, the largest existing study of beliefs and values around the world, Inglehart and Welzel (2005) diagrammed how countries were distributed on traditional/secular and survival/self expression value dimensions. The study included 81 societies, encompassing 85% of the world's population. They found that traditional societies valued obedience to God, religion, one's homeland, family, and social conformity, while secular societies valued science and autonomy. Societies that emphasize survival values are more likely to stress the importance of economic and physical security, promote traditional gender roles, constrain individual autonomy and limit contact with out-group or foreigners. In contrast, societies that value self expression emphasize human choice, well-being, and creativity.

These value dimensions suggest distinct cultural variations in the structure and quality of social relationships in general, and understanding of elder abuse in particular. For example, individualistic cultures, such as the United States, are known to value self expression and focus on maintaining relationships that are beneficial for personal goals. Intergenerational investments in family members may be more psychological than economic. While people in these cultures generally feel obligated to family, these relationships may be perceived as more voluntary in nature, and sustained on the basis of their relational quality (Kagitcibasi 1996; Oyserman, Coon, & Kemmelmeier, 2002). Cultures ascribing to collectivism and relatedness tend to believe that group membership is unchangeable (Oyserman, Coon, & Kemmelmeier, 2002). Such societies tend to maintain extended families in which young people provide direct financial help to the elderly. For instance, most Far Eastern countries exemplify these values through strict expectations of filial piety toward elders. The Chinese culture, for example, has historically promoted a strong sense of family peace, dignity, honor and respect for elders (Tam & Neysmith, 2006). While these dimensions are helpful in identifying overarching approaches toward social life in a given country or part of the world, we recognize that gradations of grey are more the rule in the increasingly mobile, interactive, diverse global society. When considering a complex issue like elder abuse, it is critical to recognize both traditional and changing values and circumstances.

To better understand how such value traditions influence elder abuse, a growing number of studies have described cultural and ethnic perceptions and definitions of elder mistreatment. Culturally situated descriptions of elders' role(s) and intergenerational expectations help illuminate why and how perceptions of and responses to elder mistreatment vary between and within different societies (Anetzberger, 1998; Arai, 2006; Brownell & Podneiks, 2005; Moon, 1993; Sanchez, 1999; Tatara, 1999; Tomita, 1999). A comparative study, for example, found that Native Americans rated behaviors as more abusive than African Americans, who were in turn, more likely to rate behaviors as abusive than were European Americans (Hudson & Carlson, 1999). Rating the relative severity of different abuse types among African American adults, younger adults rated verbal abuse as a mild form of abuse while older participants described verbal abuse as an extreme form of abuse. Neglect and abandonment were more likely to be considered extreme abuse by women as compared to men across age groups (Tauriac & Scruggs, 2006).

Highlighting inherent heterogeneity within minority groups, another study explored attitudes of elder mistreatment among a sample of four Asian American groups (Moon, Tomita, & Jung-Kamei, 2001). The authors found, for example, that American-born participants were more tolerant of verbal abuse, less likely to blame the elder parent for causing abuse and more likely to report incidents than were immigrant-born Asian Americans. On the other hand, overall Korean Americans differed significantly from other Asian groups in their tolerance of financial exploitation, blaming elders, and in reluctance to report.

The Role of Socio-economic Change: Risks for Elder Abuse

Culturally specific macro level changes also create potential risk environments for elder abuse. India and China, for example, are currently experiencing massive socio-economic change in the face of rapid industrialization, urbanization and globalization of their economies. Migration out of rural villages to cities for employment and increased rates of women entering the work force can contribute to overt or covert neglect of elders who must increasingly fend for themselves. In India, tradition has called for the elderly to live with the eldest son's family. While young Indian women have been acculturated to provide

such care to their mothers-in-law, greater educational and professional attainment among Indian women can threaten this traditional expectation and augment intergenerational conflict. Even among those adult children who wish to provide necessary care, many are required to move to the industrial centers for employment, leaving elders without the traditional safety net of their extended family. Such larger socio-economic changes thus can create or increase potential risk factors for mistreatment of elders (Jamuna, 1992).

In China, which is also undergoing rapid industrialization, recent studies of elder abuse have documented increased caregiver neglect, financial exploitation, and emotional abuse. Indeed, acute loneliness is the leading risk factor associated with elder abuse in China (Dong, Simon, Gorbien, Percak, & Golden, 2007). Similar findings have been reported in Korea, another country with a strong tradition of filial piety toward its elders. With shifts toward a more nuclear family structure and increased participation by women in the work force, older Korean parents are increasingly left alone to care for themselves (Oh, Kim, Martins, & Kim, 2005). In fact, a population-based survey found that sons and daughters-in-law, traditionally responsible for elder care, are now named as the most frequent abusers in Korea, with emotional abuse the most frequent form of mistreatment. Unlike many of the prior studies of abuse in other countries, significantly more Korean men compared with women reported overall abuse, including emotional, economic and verbal abuse (Oh, Kim, Martins, & Kim, 2005). Whether this gender difference reflects actual abuse directed toward men or a greater willingness to report remains unclear, and warrants further investigation. Such studies are critical to uncover culturally specific forms and interpretations of types of abuse and mistreatment.

Institutional Forms of Care as Context of Abuse

Specific cultural and medical models of elder care also influence meso level contributors to elder abuse. For example, institutional settings are a well established and accepted, if not optimal, option for the care of frail and infirm elders in many Western countries. While concerns and incidence of elder abuse within such settings have been documented (Hawes, 2002), the availability of institutional care can also serve to protect elders from neglect and other forms of abuse when other

resources for care are absent or insufficient. In more traditional societies, however, culture expectations dictate family care and assistance for elders. Such cultures/countries typically have very limited institutional or governmental forms of support and care in place (WHO, 2002). While these cultures do not confront elder abuse in institutional settings, the absence of such alternatives can result in a lack of protective options for elders whose family cannot or do not provide adequate care in the later years.

In the same vein, access to primary and intensive medical care for elders differs widely between diverse countries. In India, for example, access to medical care is severely limited in the villages. Unable to reach adequate health services, many older adults experience insufficient care and/or accept chronic disability as a way of life (Jamuna, 2003). Such significant societal shifts are occurring in much of the developing world, with cascading effects on the level of interaction and care of elders who remain tied to and dependent on traditional life. Unfortunately, those in the developed world who have limited access to such resources are similarly disadvantaged and vulnerable

Studies in ethnically and religiously diverse countries, such as Israel show that they face multiple pressures which may contribute to rising rates of elder abuse. Despite its small population, a large number of language groups are represented. Israel has historically accommodated large scale immigrations of refugees, recently from countries as diverse as Ethiopia and the former Soviet Union. These groups, with their own traditions and cultural histories, have had to rapidly adjust to the pressures and expectations of 21st century, industrialized urban life. Governmental social service agencies, which provide multi-generational assistance to these new immigrants, are over-extended while economic struggles at the national level have resulted in lower pension payments and service overall. Such macro level demands inevitably set the stage for higher risk for vulnerable populations within the larger society.

Finally, historical racial abuse and trauma of certain ethnic/racial groups by a dominant culture also constitute risk factors which can contribute to increased violence against and within a vulnerable or minority groups. High levels of violence in the Native and African American communities in the United States, for example, have been

traced, in part, as a response to the systemic abuse of these groups by the government (Griffin, 1998). Immigrant and refugee populations who have suffered personal and collective deprivation, warfare and genocide have also been found to have heightened levels of intergenerational abuse, including elder abuse. While macro level influences on family and elder abuse may be challenging to document, efforts must be made to understand and account for the cultural meanings of such larger historical patterns before effective interventions and supports can be implemented.

Personal and Situational Factors and Elder Abuse

The Convoy model details how personal (e.g., gender, age) and situational factors (e.g., social roles of parent, child, worker) shape social relations and affect outcomes of well-being (Antonucci, 2001). For example, it has also been noted that “the single most powerful risk marker for becoming a victim of violence is to be a woman (Walker, 1999). Cultural variation in the life circumstances, social responsibilities, and access to resources by women make them more vulnerable to and less protected from all health problems, including abuse across the life span (Simpson, 2002). Fernandez (2006) describes specific ways in which cultural expectations can play a major role of both perpetration and interpretation of violence against women across the life span. For example, patriarchal conceptions of ownership and ultimate authority over women still persist in many global cultures as well as among specific ethnic and religious groups. In such societies or groups, men are considered legally and economically responsible for their female relatives. The use of physical and psychological control, assault, and even killing of women is condoned as an acceptable means of asserting social values and/or expectations (Kulwicki, 2002; Sagot, 2005). Such cultural or group expectations present notable risks for aging women who despite disability, live longer, in greater poverty and in greater dependence on family members. Violence against women, however, remains underreported due to the sensitive nature of the subject and potential risk of retribution (Watts and Zimmerman (2002).

Circumstances affecting either or both members of a victim-perpetrator dyad, such as poverty and its consequences, isolation, alcohol abuse, mental illness, depression, and financial dependence among family

members, (Kosberg & Nahmiash, 1996; Simpson, 2002) have also been identified as potential risk factors for elder abuse (Wolf, 2000). Physical and cognitive decline, again on the part of either or both of the abusive dyad, coupled with the demands of chronic caregiving, can further place vulnerable older people at risk of elder mistreatment (Coyne, et al, 1993; Dyer, Pavlik, Murphy, & Hyman, 2000; Lachs *et al.*, 1997; Paveza, *et al.*, 1992; Pillemer & Suitor, 1992).

Future Directions

The aging of American and global societies as well as the convergence of demographic trends suggest a clear imperative to address the issue of elder mistreatment. Given the intergenerational effects of elder abuse, it is also clear, that when examining elder abuse, we must consider both structural aspects of relationships and cultural expectations of relationships across the life span. These have important influence on the risk and vulnerability of elders for abuse and mistreatment. Indeed, existing studies have done much to highlight the value of considering ethnic and cultural variation (Kosberg, Lowenstein, Garcia & Biggs, 2003). Further examinations of culturally sensitive studies of changing intergenerational expectations and attitudes towards elders will help identify behaviors that may constitute or contribute to abuse or mistreatment.

In order to accommodate such multi-level examinations, researchers in the elder abuse area must continue to address the methodological limitations that have been constrained the field. The development of shared definitions and measurements has been noted as a priority for the field by the National Research Council (2002) and others. Paradoxically, specific intervention efforts, such as mandatory reporting, often present unintended barriers to elder abuse research, while lengthy interviews or clinical approaches are sometimes inappropriate or too cumbersome for use in community samples. Accessing those vulnerable adults who are frail and/or cognitively impaired elders presents an ongoing research and intervention challenge that needs to be addressed. At the same time, alternative methods must be employed which offer the privacy and confidentiality required for highly sensitive or stigmatized topics, especially among minority communities who have grave apprehensions about agency or formal intervention (Lee & Renzetti, 1990).

In addition to methodological issues, several particularly thorny issues regarding cultural definitions and affiliation must be considered in future research. First, there is the substantial issue of whether, in a given culture or society, elders and/or women who ascribe to the traditional gender roles or intergenerational expectations actually 'feel' abused or mistreated, according to definitions that have emerged in other cultures or legal systems. This issue has been in the forefront of challenges to women who ascribe to traditional practices promoted by strict religious sects, for example. This issue certainly affects levels of elder abuse reporting, and therefore has direct effects on reliable identification of elder abuse prevalence. Similarly, development of effective intervention programs is not possible without addressing whose definition of abuse is ultimately going to apply in such settings.

A related challenge for future research and intervention efforts is the tremendous heterogeneity within racial, ethnic and religious categories and groups (Jackson, Brown, Antonucci & Daatland, 2005). Levels of affiliation within a given ethnic group, or levels of endorsement of traditional values of a given religion, for example, may be a more meaningful way to proceed in future. Of course, such nuances of affiliation are more complicated to assess, especially as these affiliations can vary within families, across generations, and across the life span. Moving beyond the use of simple categories of race, ethnicity and religion is a perennial problem. However, research of such complex phenomena as elder abuse requires the promotion of culturally sensitive and applicable knowledge in this area of global concern.

Rapid global social changes challenge existing social relations norms and traditions regarding the role and care of elders. We propose that through collaborative, cross-cultural effort, highlighting a life span perspective, researchers and policy makers may be better able to harness the greater access resulting from global interconnectivity to develop innovative approaches for dissemination of information, education and implementation of culturally relevant interventions of elder abuse and mistreatment.

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Investigating Emotional Reactions to an Elder Abuse: Pilot Study of a Triple Perspective Questionnaire

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ABSTRACT

This paper reports the results of a pilot study in Sweden examining lay persons' emotional reactions to a vignette concerning a potential elder abuse situation involving an elderly caregiver and his care receiving spouse. A questionnaire was distributed to visitors at a public exhibition and filled in on the spot. Sixty-nine persons, 11 – 73 years old, participated. All questionnaires used the same basic vignette but half specified rheumatism and half specified Alzheimer's disease in the potential abuse victim. Participants rated emotional reactions from three different perspectives; how they themselves reacted, and how they thought the caregiver and the care recipient would each react emotionally. Emotional reactions were explored through questionnaire items Anger, Impatient, Shame, Disgust, Concern, Embarrassment, Compassion, Irritation, A desire to help, Insecure, and Frightened. Results showed differences between participants' own reported reactions and the reactions they expected the older persons to experience. These differences were especially noticeable between questionnaire versions. Analysis also indicated differences in response patterns that were related to participants' gender and marital/cohabitation status. This pilot study revealed several fruitful avenues for refinement of the questionnaire and for further investigation of emotional reactions to elder abuse.

Keywords : Elder abuse, Emotional reactions, Indifference of participant, Gender difference.

Which actions we take when witnessing an elder abuse situation not only depends on existing legislature, verifiable risk factors, or available intervention programs, but also with how we perceive the situation (Erlingsson, 2007a). Yet perceptions are only partially based on ethical reasoning such as the reasoning reflected in written laws. Our perceptions also have deep roots in our beliefs and emotions (Fridja *et al.*, 2000). Therefore it is crucial to study not only how potential elder abuse witnesses in society reason and *think* about elder abuse situations but also how potential witnesses *feel* about elder abuse.

Research studies on witnesses' perceptions of elder abuse have primarily involved professionals such as physicians, nurses, and social workers (Erlingsson, 2007b) and found differences in how participants perceive elder abuse related to, e.g., age, gender, profession, and culture (Erlingsson, 2007a). There are only a handful of studies examining perceptions among lay persons (cf Erlingsson *et al.*, 2005; Gebotys *et al.*, 1992; Hudson, 1996; Moon and Williams, 1993). In several studies participants described feeling reluctant to take action when witnessing a situation of suspected elder abuse (Erlingsson, 2007a). However research on how emotional reactions form our perceptions of elder abuse is almost non-existent. An important exception to this is a study conducted by Werner, Eisikovitz, and Buchbinder (2005) on lay persons' emotional reactions to elder abuse. One thing all these studies have in common is that participants are reporting how they themselves perceive elder abuse. But can we content ourselves with only exploring the complex phenomena of elder abuse through a single lens perspective, i.e. through the lens of "I perceive"?

Our actions are also affected by what we assume other actors in the drama are experiencing. Beliefs about what others are feeling and why they are feeling as they do, influence our experiences of emotions and how we react to our emotions (Clark and Brissette, 2000). It seems likely that it is a combination of perception perspectives that guides actions. The aim of this present study was to examine lay persons' emotional reactions to a potential elder abuse situation from the triple perspective of 1) how they themselves feel, 2) they perceive the potential abuser feels, and 3) how they perceived the potential victim feels.

Method

The executive branch of the European Union, the European Commission, founded the European "Night of the Researcher" in 2006. As part of this initiative, the University of Kalmar held a two hour long exhibition, open to the public where Kalmar researchers presented projects and provided information about their areas of study. Persons walking by or visiting my booth exhibiting elder abuse research were asked if they wanted to be on-the-spot participants in an elder abuse study and invited to participate in the pilot study. Children were requested to first ask for permission from their parents or accompanying adult before participating. Participants represented both the general public and people associated with the University of Kalmar. My four assistants and I provided information about the study and instructions on how to fill in the questionnaire.

Questionnaires investigated emotional reactions to an elder abuse situation and were based on an instrument used by Werner *et al.* (2005) examining lay persons' self-experienced emotional reactions to a vignette concerning a situation of potential elder abuse. On the first page of the questionnaire participants were asked to respond about demographics (age, gender, occupation, education, marital/cohabitation status, and number of children). Participants then were to read and respond to items related to the vignette. Lastly participants were asked if they had perceived the vignette as an elder abuse situation and if they had personal experience of a situation where an older person had been abused. If answered positively there were follow-up questions about the relationship between the abused person, the victim, and the participant.

Questionnaires were based on two versions of the same vignette. The questionnaire used in Kalmar named the potential victim as either suffering from Alzheimer's disease (Ques-Alz) or rheumatism (Ques-Rh) (see Table 1 for explanation of abbreviations). The face validity of the vignette was first assessed by five teachers in the School of Human Sciences, University of Kalmar before questionnaires were piloted. In the current pilot study, 69 questionnaires were completed (33 included the vignette where the wife suffers from Alzheimer's disease, and 36 included the vignette where the wife suffers from rheumatism).

In order to examine emotional reactions, participants were to first read the following vignette:

Sara Larsson is your 78 year old neighbor. She lives with Karl, her husband for the last 54 years. The couple has a son who lives nearby and provides assistance with everything his parents need help with. You know that Sara suffers from Alzheimer's disease (rheumatism). That is why home care personnel visit the couple twice weekly to help Sara take a shower and with other activities. Yesterday you met the couple near their home and noticed that Sara has several bruises on her arms and face. When you ask her what happened to her, Karl answered that she fell at home. Sara shouted, "I was beaten! I was beaten!"

After reading the vignette, participants rated 33 items. This entailed rating 11 alternative endings to each of three statements about emotional reactions. In the first statement, participants were to respond from their own, self-experienced perspective ("When I read this vignette I feel..."). Participants were then to respond to same 11 alternative endings but from the perspective of what the husband in the vignette would feel ("When I read this vignette I believe Karl feels..."). In the third statement participants were to respond from the perspective of what the wife in the vignette would feel ("When I read this vignette I believe Sara feels..."). Participants were to rate the same eleven alternative endings under each statement. These 11 alternative endings were "Anger", "Impatient", "Shame", "Disgust", "Concern", "Embarrassment", "Compassion", "Irritation", "A desire to help", "Insecure", and "Frightened". Participants rated each item on a four-level Likert scale (Do not agree, Agree to a low extent, Mostly agree, Agree to a high extent).

Responses were analyzed using computer software SPSS 15 for descriptive statistics, examining frequencies and cross-tabulations. Data was explored to see if sub-groups could be formed that would elucidate variations in the data and still represent adequate group size. Small sample size (see Table 2) and diversity in participants' age, number of children, type of employment, and years of schooling limited using these variables in formation of sub-groups. Questionnaire version (Ques-Alz or Ques-Rh) and participant's gender were variables that provided sufficient sub-group size. On closer scrutiny it could be seen that layering

the cross-tabulations of questionnaire version/participants' gender with data on marital/cohabitation status revealed clear variations. Eight sub-groups were formed based on participants' gender, marital/cohabitation status, and questionnaire version (see Table 1). It must be reiterated and strongly emphasized that this was an extremely small sample and that this was a pilot study of an untested questionnaire. As such, results are only indicative of possible directions for further development and utilization of the questionnaire. Having said as much let us still take a look at some interesting results.

Table 1. Response classifications and abbreviations used for questionnaire versions and participant sub-group descriptions

Response classifications;	
A	= Agreement with the statement-specific item (Alternatives "Agree to a high extent" + "Mostly agree" $\geq 70\%$)
(A)	= Agreeing more than disagreeing with the statement-specific item (Alternatives "Agree to a high extent" + "Mostly agree" $\geq 60\% - \leq 69\%$ of responses)
+/-	= Neither agreeing nor disagreeing with the statement-specific item (Alternatives "Agree to a high extent" + "Mostly agree" and response alternatives "Agree to a low extent" + "Do not agree" are both between 41% - 59% of responses)
(D)	= Disagreeing more than agreeing with the statement-specific item (Alternatives "Agree to a low extent" + "Do not agree" $\geq 60\% - \leq 69\%$ of responses)
D	= Disagreement with the statement-specific item (Alternatives "Agree to a low extent" + "Do not agree" $\geq 70\%$)
Questionnaire version abbreviations;	
Ques-Alz;	Questionnaire version based on vignette specifying Alzheimer's disease
Ques-Rh;	Questionnaire version based on vignette specifying rheumatism
Participant sub-group abbreviations;	
Cohab@& :	Males, married or cohabitating
Cohab@&:	Females, married or cohabitating
SingleB&:	Males, unmarried and not cohabitating
Single@&:	Females, unmarried not cohabitating

Table 2. Age range and number of participants in total sample and sub-groups

	Age range	Number of participants		
		In total sample	Ques-Alz	Ques-Rh
Total sample		69	33	36
	10 – 19 yrs	22	12	10
	20 – 39 yrs	25	12	13
	40 - e"65 yrs	18	6	12
Sub-groups		65*		
CohabB&	25 - e"65 yrs.	15	6	9
SingleB&	10 - e"65 yrs.	15	9	6
Cohab@&	20 – 64 yrs.	20	8	12
Single@&	10 – 44 yrs.	15	7	8

*Missing values for age, gender, or marital/cohabitation status for 4 participants

Results

Results were classified (see Table 1) according to the level of agreement or disagreement (A, (A), +/-, (D), or D) and are presented on the level of total sample, questionnaire version, participant sub-group, statement, and statement-specific items (see Table 3). Results were further explored by ranking items according to number of A or D responses (see Table 4), and comparing percentages of A or D responses among participant sub-groups (see Table 5). The reasoning behind reporting results in this manner is that potential trends in responding to the questionnaires, within and between groups, could become more visible.

In response to the query if the vignette was describing a situation of elder abuse, 80 % answered yes in the total sample (79 % in Ques-Alz and 81 % in Ques-Rh), 10 % answered no, and 10 % had unclear or no response.

Discussion

First some of the noteworthy results of the pilot study will be highlighted. Following this the methodology of the questionnaire is considered and, lastly, conclusions about future use of this questionnaire are discussed.

Pilot study results

The classification of responses as A or as D indicates results where participants were responding very similarly to each other. Responses classified as (A), +/-, or (D) reveal instead a diversity in participants' response patterns. One reasonable hypothesis is that A or D response patterns indicate items participants could respond to in a confident manner. Results classified as A or D can be considered as representing an opinion held generally by the participants. It follows that the reverse situation, diverse response patterns, could be indicating items that are more difficult to take a stand on, i.e., items where participants were less certain of how to respond. In total sample results for example, it would seem that participants were most confident in their responses in connection to items in the emotion "Concern" and least confident response pattern for items in connection to the emotion "Disgust" (see Table 3 and Table 4).

Table 3 : Level of agreement or disagreement with items in total sample, questionnaire versions, and participant sub-groups

		Total Sample (QuesAlz + QuesRh)	Total sample		Cohab.		Cohab.		Single		Single	
			Ques Alz	Ques Rh	Ques Alz	Ques Rh	Ques Alz	Ques Rh	Ques Alz	Ques Rh	Ques Alz	Ques Rh
Angry	I feel	+/-	+/-	(A)	+/-	(A)	D	A	(A)	(A)	+/-	+/-
	Karl feels	(A)	A	+/-	+/-	+/-	A	A	+/-	(A)	(A)	+/-
	Sara feels	A	A	(A)	+/-	(D)	A	A	A	(A)	+/-	A
Impatient	I feel	(D)	D	(D)	+/-	(A)	D	D	D	(A)	+/-	D
	Karl feels	+/-	(A)	(D)	+/-	(D)	A	A	+/-	(D)	+/-	D
	Sara feels	+/-	(A)	+/-	(D)	+/-	A	D	A	+/-	+/-	A
Shame	I feel	D	D	(D)	D	+/-	D	D	D	D	+/-	(D)
	Karl feels	A	(A)	A	(A)	A	+/-	A	(A)	+/-	A	A
	Sara feels	+/-	(D)	(A)	+/-	A	D	A	+/-	(A)	D	(D)
Disgust	I feel	(A)	+/-	A	+/-	+/-	+/-	A	+/-	(D)	+/-	+/-
	Karl feels	(D)	D	+/-	D	+/-	D	(D)	(D)	(A)	(D)	+/-
	Sara feels	(A)	+/-	(A)	+/-	A	+/-	+/-	A	A	+/-	A

Concern	I feel	A	A	A	A	A	A	A	A	A	(A)	A
	Karl feels	A	A	A	A	A	+/-	A	A	(A)	+/-	A
	Sara feels	A	A	A	(A)	A	A	A	A	A	(A)	A
Embarrassment	I feel	D	(D)	D	D	(D)	D	(D)	D	D	+/-	D
	Karl feels	(A)	(A)	+/-	+/-	A	D	(D)	A	D	A	A
	Sara feels	+/-	(D)	+/-	(D)	+/-	+/-	(D)	+/-	(A)	D	+/-
Compassion	I feel	A	A	A	(A)	A	A	A	A	A	(A)	(A)
	Karl feels	(D)	+/-	D	(D)	D	A	D	(D)	D	(A)	+/-
	Sara feels	D	D	D	D	D	D	D	D	D	D	D
Irritation	I feel	+/-	(D)	+/-	(D)	A	+/-	D	(D)	(A)	+/-	+/-
	Karl feels	A	A	(A)	A	A	A	+/-	A	+/-	(A)	A
	Sara feels	A	A	(A)	A	+/-	A	A	A	(D)	+/-	A
Desire to help	I feel	A	A	A	+/-	A	A	A	(A)	+/-	A	A
	Karl feels	+/-	(A)	D	(D)	D	+/-	D	(A)	(D)	A	D
	Sara feels	A	A	A	A	A	A	A	A	A	A	A
Insecure	I feel	D	D	D	D	D	D	D	(D)	D	+/-	D
	Karl feels	(A)	+/-	(A)	+/-	A	D	+/-	(A)	(A)	(A)	D
	Sara feels	A	A	A	A	A	A	A	A	A	A	A
Frightened	I feel	D	D	D	D	D	D	D	+/-	D	+/-	D
	Karl feels	A	(A)	A	(A)	A	+/-	A	(A)	(A)	(A)	A
	Sara feels	A	A	A	A	A	A	A	A	A	A	A

Table 4. Emotions ranked from greatest number of A or D responses to fewest A or D responses in the total sample and statement-specific items

	Total Sample	Statement-specific items		
		“I feel...”	“Karl feels...”	“Sara feels...”
Greatest # of A or D responses	- <i>Concern</i>	- <i>Concern</i>	- <i>Concern</i>	- <i>Compassion/</i>
	- <i>Frightened</i>	- <i>Insecure/</i>	- <i>Irritation</i>	- <i>Desire to help/</i>
	- <i>Desire to help</i>	- <i>Frightened</i>	- <i>Embarrassment</i>	- <i>Insecure/</i>
↓	- <i>Compassion</i>	- <i>Compassion/</i>	- <i>Shame</i>	- <i>Frightened</i>
↓	- <i>Insecure</i>	- <i>Desire to help</i>	- <i>Frightened</i>	- <i>Concern</i>
↓	- <i>Shame</i>	- <i>Shame/</i>	- <i>Compassion/</i>	- <i>Irritation</i>
↓	- <i>Irritation</i>	- <i>Embarrassment</i>	- <i>Desire to help</i>	- <i>Angry</i>
↓	- <i>Embarrassment</i>	- <i>Impatient</i>	- <i>Disgust/</i>	- <i>Shame</i>
Fewest # of A or D responses	- <i>Angry</i>	- <i>Angry/</i>	- <i>Angry</i>	- <i>Impatient/</i>
	- <i>Impatient</i>	- <i>Irritation</i>	- <i>Insecure/</i>	- <i>Disgust</i>
	- <i>Disgust</i>	- <i>Disgust</i>	- <i>Impatient</i>	- <i>Embarrassment</i>

Note: Marked items in *italics* share same rank

When it came to revealing the diversity of response patterns in the data, total sample results however did not tell “the whole story”. As can be seen in Table 3, results classified +/- in the total sample were either, 1) confirmed in sub-groups by the majority of responses classified as +/-, (A) or (D), or 2) due to opposite responses in Ques-Alz and Ques-Rh within the same sub-group. “I feel angry” exemplifies the first case showing how diversity in sub-groups’ responses supported +/- in the total sample. Item “Sara feels shame” exemplifies the second case, showing how opposite responses in or between sub-groups supported +/- in the total sample. This lack of correspondence was frequently observable between total sample results, questionnaire version results, and participant sub-group results, and points to how valuable it is to view results through different lenses of questionnaire version and participant sub-groups.

One third of the items in the total sample results, showed confident response patterns, i.e., results classified as either A or D. These were “I feel concern”, “Karl feels concern”, “Sara feels concern”, “I feel compassion”, “Sara feels compassion”, “I feel a desire to help”, “Sara feels a desire to help”, “I feel insecure”, “Sara feels insecure”, “I feel frightened”, “Sara feels frightened”. When considering total sample results together with participant sub-group results, only four of these items showed exclusively A or D responses both for the total sample and participant sub-groups; “Sara feels compassion”, “Sara feels desire to help”, “Sara feels insecure”, “Sara feels frightened” (see Table 3). It is interesting to note that there was only one “Karl feels...” item classified as A or D in the total sample and no “Karl feels...” item among items with responses classified exclusively as A or D in the total sample and participant sub-groups results taken together.

When ranking responses in the total sample and statement specific items, it was also “Karl feels...” items that most strongly diverged from ranking patterns otherwise observable in the “I feel...” items, and “Sara feels...” items, and in the total sample results. This was especially clear when considering three items; “Karl feels irritation”, “Karl feels embarrassment” (more A or D responses than in total sample or other sub-groups), and “Karl feels insecure” (fewer A or D responses than in total sample or other sub-groups) (see Table 4). Responses to

statements connected to “Karl feels...” also showed the lowest percentage of A or D responses compared to statements connected to “I feel...” and “Sara feels...” (see Table 5). This diversity and divergence in response to items concerning how Karl feels could signify that it was either 1) generally difficult to put oneself in Karl’s position, or 2) that participant’s personal situation (e.g. gender, age, or marital/cohabitation status) affect how participant’s believe Karl feels.

Table 5. Comparison of percentages of items classified A or D in total sample and sub-groups regarding questionnaire version and statement (“I feel”, “Karl feels”, and “Sara feels”)

Sub-groups		% of items classified A or D	% of items classified A or D in each of the three % of items		
			“I feel...”	“Karl feels...”	“Sara feels...”
			Cohab	Ques-Alz + Ques-Rh	51 %
	Ques-Alz	39 %	45 %	27 %	45 %
	Ques-Rh	64 %	55 %	73 %	64 %
Cohab	Ques-Alz + Ques-Rh	77 %	82 %	64 %	82 %
	Ques-Alz	76 %	82 %	64 %	82 %
	Ques-Rh	79 %	91 %	64 %	82 %
Single	Ques-Alz + Ques-Rh	47 %	50 %	23 %	68 %
	Ques-Alz	52 %	45 %	27 %	82 %
	Ques-Rh	42 %	55 %	18 %	55 %
Single	Ques-Alz + Ques-Rh	50 %	32 %	50 %	68 %
	Ques-Alz	30 %	9 %	27 %	55 %
	Ques-Rh	70 %	55 %	73 %	82 %
Average in Sub-groups	Ques-Alz + Ques-Rh	56 %	54 %	47 %	68 %
	Ques-Alz	49 %	45 %	36 %	66 %
	Ques-Rh	64 %	64 %	57 %	70 %
Total sample		% of items classified A or D	“I feel...”	“Karl feels...”	“Sara feels...”
	Average in total sample	54 %	64 %	36 %	64 %
	Ques-Alz	54 %	64 %	36 %	64 %
	Ques-Rh	51 %	64 %	45 %	64 %

Karl’s role in the vignette is kept purposely vague so that each participant must decide if Karl is an abuser or a harried caregiver. Earlier research on perceptions of abusers describes how both lay persons (Erlingsson *et al.*, 2005; Grafström *et al.*, 1993) and professionals (Erlingsson *et al.*, 2006; Limandri and Tilden, 1996; Saveman *et al.*, 1993) see caregivers from several perspectives simultaneously and have difficulties seeing the caregiver only as a villainous abuser. Diverse and divergent responses to “Karl feels...” items also indicate that this decision was difficult for participants to make and, perhaps, that participants considered Karl both a harried caregiver and abuser.

Participant sub-group Single B& showed the most diverse response pattern of any sub-group (47 % items classified as A or D responses). This was especially noticeable in that Single B& had only 23 % A or D responses to items under “Karl feels...”. The sub-group Cohab @& was most confident in rating items as can be seen in the high percentages of responses classified as A or D (77 %). Confident rating was especially visible in items connected to statement “I feel...” and “Sara feels...” (82 % of sub-group’s responses to each statement classified as A or D) (see Table 5). Why single men showed lowest percentages of A or D responses while Cohab @& showed the most confident response patterns will be an interesting avenue for further investigation.

Another interesting result is seen in items connected to the emotion “Concern”. All three perspectives (“I feel...”, “Karl feels...”, “Sara feels...”) had results classified as A or (A) both in the total sample and in participant sub-groups, with the fewest number of responses classified +/-, and no D or (D) results (see Table 3). In comparison with other emotions in the questionnaire, “Concern” also stands out as one of the least value-laden items, carrying a fairly neutral meaning. One may feel concern in situations involving either love, hate, violence, caring, or sickness. Taking this into account, “Concern” should perhaps be changed in future versions of the questionnaire to “Unconcerned”. Another approach would be to include in the questionnaire a question asking participants if they would agree to a follow-up telephone interview during which researchers could further investigate what had motivated a participant’s response.

Response patterns to an emotion frequently differed, both in the total sample as well as in all sub-groups, according to whether participants were responding to the “I feel...”, “Karl feels...” or “Sara feels...” perspective. One example of this is “Compassion” where the item “I feel compassion” had responses classified only as A or (A) while participants only disagreed with the item “Sara feels compassion”. The opposite could be observed in “Frightened” where participants mostly disagreed with the item “I feel frightened” but exclusively agreed with the item “Sara feels frightened” (see Table 3). These results, showing differences in reported emotional reactions from the same participants when taking different perspectives, once more raises questions concerning what it is that motivates witnesses to take action in cases of suspected elder abuse. Do we act based on how we ourselves feel or based on how we think the abused or the abuser are feeling? These results and reflections raise the question of whether a questionnaire item, currently absent from the questionnaire, needs to be included; i.e. a specific question at the end of the questionnaire asking if and/or what action the participant would take if actually witnessing a situation as described in the vignette.

Response patterns also differed depending on whether participants were responding to the Ques-Alz or Ques-Rh. These differences were especially noticeable in three statement-specific items; “Sara feels shame”, “Karl feels compassion”, and “Karl feels a desire to help”. These questionnaire-version-dependent differences were consistent both in the total sample and participant sub-groups. In item “Sara feels shame” there was a trend to agree more with this item in Ques-Rh than in Ques-Alz. In two other items “Karl feels compassion” and “Karl feels a desire to help”, there was a trend to disagree more with the item in Ques-Rh than in Ques-Alz (see Table 3).

Consistently higher percentages of responses were classified as A or D in the Ques-Rh than in Ques-Alz (see Table 5). The only two exceptions to this were responses to items in connection to “Karl feels...” and “Sara feels...” from sub-group Single B&. Cohab B& and Single @& were the two sub-groups with greatest difference in percentages of items classified as A or D between the two questionnaire versions. This is especially marked in Single@& ratings with 30 % items classified

as A or D in the Ques-Alz but 70 % of items classified as A or D in the Ques-Rh. As a sub-group Single@& had only 9 % A or D responses to “I feel...” items in Ques-Alz compared to 55 % in Ques-Rh. (see Table 5).

Most dramatic differences between Ques-Alz and Ques-Rh could be seen when opposite responses for the same item were seen within the same sub-group. Opposite responses to the same items in Ques-Rh and Ques-Alz from the same sub-group were observed six times; in the sub-group Cohab @& (“I feel angry”, “Sara feels impatient”, “Sara feels shame”, “Karl feels compassion”), in the sub-group Single B& (“Karl feels embarrassment”), and in the sub-group Single @& (“Karl feels a desire to help”). That the sub-group Cohab @& was at times responding differently depending on the questionnaire version while the sub-group Cohab B& did not, is an area needing further investigation. Earlier research, such as the study by Childs *et al.* (2000), has found that gender and age play a role in how we perceive elder abuse. An extremely interesting line of investigation would be to test whether it is primarily age, gender or experience of living in a marriage-like relationship that affects how we react emotionally to the vignettes and items in the two questionnaire versions.

Methodological aspects of the pilot questionnaire

Results from the pilot questionnaire indicated several areas for questionnaire improvement. As mentioned earlier, some of the included emotions need to be reconsidered. Pilot results have also prompted the idea that an additional question should be added to the end of the questionnaire specifically asking if and/or what action the participant would take if actually witnessing a situation as described in the vignette. A second idea generated by pilot results is to include a question asking participants if they would agree to a follow-up telephone interview during which researchers could further investigate what had motivated a participant’s response.

Another methodological issue is that it remains unknown whether participants were responding as they thought Karl or Sara *actually* feel, or were participants responding as they thought Karl and Sara *ought to* feel? This ambiguity must be addressed in a revised questionnaire by including additional clarification. An interesting

modification of this questionnaire would be to expand from three basic questions to six questions, e.g., “I actually feel...”, “I ought to feel...”, “Karl actually feels...”, “Karl ought to feel...”, “Sara actually feels...”, and “Sara ought to feel...” The advantage with this is that it would both clarify which question the participant is responding to and shed light on ethical reasoning behind how participants have responded. The obvious disadvantage is that 33 items in the pilot questionnaire would triple to 99. Lengthening the questionnaire increases the risk that participants tire, lose interest and leave the questionnaire unanswered. This risk is especially high if an impersonal, postal distribution is chosen. A second disadvantage of lengthening the questionnaire is that the number of participants required for adequate power in order to, e.g. conduct factor analysis greatly increases (Polit and Beck, 2008). These aspects will need to be weighed before constructing the next version of the questionnaire.

The motivation for using a four-point Likert scale in the pilot questionnaire was to “force” participants away from choosing a neutral response. Results of the pilot and of earlier studies (Werner *et al.*, 2005) indicate however that a neutral response could be a result in itself, i.e., that the situation didn’t elicit any especially strong emotion. Emotions can be confusing experiences and although some may be easier to grade on a black and white, “either/or” four-point scale, there are perhaps those emotions that need the midpoint/neutral answer alternative. This suggests that further development of the questionnaire will involve utilizing a five-point Likert scale. A second motivation for using a five-point Likert in future utilization of this questionnaire is that it will facilitate comparison to earlier studies of lay person’s reactions to elder abuse (cf Werner *et al.*, 2005).

Future use of the questionnaire

The results of the questionnaire pilot clearly showed that it is a fruitful effort to use two versions of the questionnaire and a triple perspective for examining emotional reactions to a vignette about a potential elder abuse situation. Results also show that analyzing responses through the different lenses of participant sub-groups and layered by questionnaire version provides valuable information.

Several results suggest ways to improve the questionnaire and point to possible avenues for future research. For example, why did single men show the most diverse answering patterns while married/cohabitating women the most confident response patterns? And why did married/cohabitating women sometimes respond differently depending on questionnaire version while the married/cohabitating men did not? An extremely interesting line of investigation will be to test whether it is primarily age, gender or experience of living in a marriage-like relationship that affects how we react emotionally to the vignettes. Most importantly though will be to investigate on a larger scale lay persons’ and professionals’ emotional reactions to elder abuse and how these reactions and feelings affect our actions or inaction as witnesses to elder abuse.

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Intergenerational Justice: An Israeli Perspective

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ABSTRACT

Intergenerational equity is a central issue not only in gerontological theories but for the gerontological field at large. This concept makes possible the social construction of old age, which entails social policy outcomes, and provides another important angle to issues of justice, abuse and neglect of older people. The fairness of financial redistribution between generations has significant impact on the development of social services, privatization, and shifts in social policy. When looking closer at these issues within the Israeli social context, a complex and incoherent picture emerges.

Key Words: Intergenerational Justice, Intergenerational Transfers, Elder Abuse and Neglect, Elder Rights.

The article describes and analyzes the development of social welfare policies in Israel, in the context of intergenerational justice. The analysis is done with special attention to the changes in the Israeli definition and structure of the welfare state. The article includes three parts: Part One introduces the various theoretical approaches to intergenerational justice that are currently prevalent in the Western world, along with empirical data in this field. Part Two examines the developing themes in this field in Israeli social policy, along with specific examples in the realm of old age, and with emphasis on the phenomena of elder abuse and neglect. Finally, the concluding section presents policy recommendations regarding intergenerational justice, in the light of today's Israeli reality.

The intergenerational contract is an ancient concept. Today, demographic changes in the Western world and the post-modern approach to the study of social reality challenge us to rethink the concepts of social solidarity, obligation, and mutuality between generations. The concept of generational equity or intergenerational justice has developed as a result of the ageing of the population, shortfalls in the government's budget, a crisis in health services, and inequality of incomes.

Intergenerational equity is an important component of various gerontological theories and of gerontological literature in general. It makes the social construction of old age, with its implications for policy, possible. Generational equity refers to the concept that different generations should be treated in similar ways and should have similar opportunities. However, this debate stems from the growing rate of elders in the population and is usually related to the conflict approach – division of economic resources between generations – ‘generational negotiation’ for resources (Collard, 2001) and in the manner of each generation activating power and social control (Dunham & Bengtson, 1986).

Fairness in the distribution of resources between different age groups influences the privatization of services and changes in social policy. None the less, when various aspects of the concept, and the degree to which it is implemented in social policy, are examined in the Israeli context, a complex and interesting picture, in which it is hard to find consistency or clear uniformity, is revealed.

In this article we shall examine changes in Israeli welfare policy with regard to questions of intergenerational justice and intergenerational transfers, in light of the ways in which the concept of the welfare state has changed. The article has three parts: the first is a brief sketch of the main theoretical approaches to intergenerational justice accompanied with empirical findings from the world at large and from Israel. In the second part we shall examine the trends now developing in Israel in this respect, on the basis of data relating to the extent of poverty among various age groups, to the transition from a public, pay-as-you-go, pension system to a privatized, defined contribution, pension system, and to the controversy about retirement age. The third, concluding

section, deals with the implications of these changes for social fabric and social solidarity in Israel.

Part A: Principal Approaches and Empirical Data on Intergenerational Transfers

Intergenerational transfers are an integral part of one's own life cycle and his or her family's life cycle. Hence, the patterns of consumption and saving of each individual are determined not only by him or her self, but by other individuals that surround them, most importantly, his or her familial transfers. Further, the family differs from the labor market or the welfare system in that it is a social framework for the preservation of rights and their transmission from one member of the family to another. The recent research on family transfers – both inter vivos and as bequests – demonstrates that transfers are considerable, that they occur mostly in the generational lineage, and that they flow mostly downwards, from the older to the younger generations (Kohli, 1999). There may be expectations of reciprocity, or other strings attached, but by and large parents are motivated by altruism or feelings of unconditional obligation, and direct their gifts to situations of need.

Three main approaches to intergenerational family transfers are presented in the literature: the normative approach, the altruistic approach, and the strategic approach.

The normative approach views intergenerational transfers as exchanges of ‘functions’: the descendant transfers functions to his/her parents, just as they transferred theirs to their parents. This approach calls for an analysis of the social/historical process of intergenerational transfers over a specified period of time. The intergenerational transfer is conceived of as a key component in the continuity of the process of preserving family solidarity, and it has long-term social implications. On the macro level, this procedure constitutes a normative contract, similar, for example, to that established by the Social Insurance Law. At the level of the family it is a complex of values, norms, and family obligations. Research in Israel and four European countries (Norway, England, Germany and Spain) — the Oasis research project¹ shows that most of the respondents (1,200 in each country, 6,000 in all) in every country spoke of a relatively high degree of normative obligation,

though this was highest in Israel, Spain and Germany. None the less, even in countries such as Norway, which is still a comprehensive welfare state, the fact that there is a wide range of social services did not impair family responsibility and obligation – filial duty between the generations. (Lowenstein, Katz & Daatland, 2004; Lowenstein & Daatland, 2006). Similar results, highlighting the importance of intergenerational norms and relationships among young and old alike, have been obtained in Europe (Walker, 1993) and the US (Bengtson & Roberts, 1991).

The altruistic approach conceives of intergenerational transfers as the result of a special type of feeling of obligation, as distinct from considerations of advantage for individuals. The concept of altruism embraces love, concern, and solicitousness of each generation for the other. According to this approach, the ‘strong’ individual in the family takes on him/herself the care for the others, as a result of love and concern. This approach matches the concept of ‘role reversal’: in the early stage of the life cycle the parent is the altruist, but during old age the descendant takes on him/herself the role of the carer, from similar altruistic motives. Logan & Spitze’s (1995) findings demonstrate the presence of altruism, as opposed to expediency, and emphasize the strength and importance of altruistic norms in the framework of filial responsibility in different groups defined by origin, gender and age. It is of some interest that the findings show that support for these norms is consistently higher among the younger age groups than among the older. This is in contrast to the Generational Stake phenomenon” (Giarrusso, Stallings, and Bengtson, 1995; Thompson, Clark, & Gunn, 1985) which reflects a pattern in which older generations perceive intergenerational relations in a more positive light than do younger generations. This pattern is explained by the developmental imperative of older generations to emphasize continuity with younger generations and of younger generations to emphasize autonomy from older generations (Bengtson & Kuypers, 1971).

According to the strategic approach, social interaction is based on the fact that individuals’ expectations (which determine their concrete actions) are influenced by the actions of others. Transfers are part of an extended process of exchange. On this view, intergenerational transfers are subject to rational considerations, according to which both

parties profit, or at the least neither is harmed. Mutuality plays a decisive part in this approach, like exchange transactions in sociological theories based on the work of Homans (Homans, 1960), or in the theory of conflict solution in social psychology (Thilbaut & Kelley, 1959). Such mutuality or reciprocity is to be found for example in the Oasis research project (Lowenstein, Katz & Gur-Yaish, 2007).

Transfers may also be conceived of as family transactions. There may be four types of intergenerational transfers within the family: those which can be classified as insurance transactions; those which can be classified as capital transactions – economic/financial transfers; those which can be classified as labor transactions – transfer of time or working services, as when physical care is required; and transfers which are mainly in the affective sphere of emotional aid and support.

As a result of the development of the capital market and systems of assurance of income and pension, the economic/financial situation of a number of old people (even though a relatively small proportion of them) is no worse than that of the rest of the population, since those in this group have invested in insurance and pension schemes during their working life. On the other hand, technological and medical developments have led to the existence of a relatively long period of ‘handicapped living’ in the course of which the old person needs help in his/her daily activities. As a result, the main requirements of old people, and particularly the ‘old old’ (aged 75 and above) are connected with the deterioration of their functional capabilities and the need for tangible services and support. Thus, the public generational contract is partly balanced by a private one in the opposite direction. The family transfers function to some extent as an informal insurance system for periods of special needs.

It should be, however, acknowledged that the potential for distributional conflicts among generations exists and is fuelled by the current challenges of public finances and demography. In view of all this, it is not surprising that financial transfers from descendants to the old constitutes a small proportion of their income. The findings of the Oasis survey moreover show that older parents in four of the countries (Norway, England, Germany and Israel) except Spain also provided financial assistance to their children (Lowenstein, Katz & Gur-Yaish, 2007). On the other hand, transfers in terms of time and labor constitute

a decisive proportion of the support which old people receive from their adult children, despite the development of formal services, particularly in Israel under the aegis of the Israeli Community-Based Nursing Insurance Law.

The controversy concerning intergenerational equity

It is generally accepted today that the very act of raising the topic of intergenerational equality or justice serves to create a social construct in which interest groups, social groups and policy-makers endeavor to justify the 'deterioration' or 'retreat' in the extent of the welfare services play a role. This includes the endorsement of ideologies such as that of individualism, the competitive market, and the transfer of responsibility from the state to the family also in matters of care for the aged. It is claimed that these processes increase social inequality.

Moreover, a major limitation of the generational equity frame is that it provides a rationale to base policy on age or age cohort and to discount other forms of equity based on race, ethnicity, class, gender, and sexual orientation. As Norman Daniels has argued, "Justice between age groups is a problem best solved if we stop thinking of the old and the young as distinct groups. We age. The young become the old. As we age, we pass through institutions that affect our well-being at each stage of life, from infancy to very old age" (p. 18). Also, the perspective on generational equity is usually restricted to public resource flows, and neglects the private side – the transfers between family generations (Kohli, 2005).

In the US an organization known as AGE (Americans for Generational Equity) and, in parallel, an organization known as Generations United, have been set up. The latter is a coalition of more than a hundred health and welfare organizations which support an intergenerational policy approach.

In fact, as Levin-Epstein (2001) maintains, an overall analysis of social inequality entails consideration of the labor market, the welfare system, and the family set-up. When the welfare system abandons its function of reducing the dangers to which the populations which it encompasses are exposed, this disturbs the delicate balance between these three systems. It increases the importance of the family as a social system which combats the dangers threatening its members; as

a result, the state can 'shrug off' its responsibility for the weak sectors within it.

In the opinion of Binney & Estes (1988), the approach to the unequal allocation of resources between the generations with respect to the welfare services has rested on two mistaken assumptions made by economists, demographers, politicians and the media. One is connected with the old age dependency ratio. This assumption is based on a comparison between employed and retired populations, which does not take into account the 'institution of retirement', or the fact that the economic system does not provide employment for every individual. The other assumption is connected with the 'zero-sum' concept, which relates to the belief that goods and services are limited, and that benefits are provided for one generation at the expense of another. In the context of this paper, this means that the provision of grants and pensions for the ageing population reduces the benefits enjoyed by younger generations. This is reflected in the statistics of poverty among children, compared with the rise in the standard of living of the old.

However, these statistics ignore that fact that a high proportion of the expenditure connected with old people – for instance, retirement funds and pensions – is not financed by the state, but by the workers and their employers. According to Israeli statistics, the level of income of some 70% of the old population is less than three quarters of the average wage in the economy; and the situation of old immigrants is even worse. In addition, about 30% of the old have only their old-age or survivor's pension to live on, and are, therefore, below the poverty line. Inequality continues to increase and to spread, and recent economic restrictions have been particularly hard on old people. The statistics about the level of income of poor families are similar. Even if old people have recently been less hard hit than, for instance, single parent families, in the long run the impact of the adjustment of pensions, will lead to a reduction of the pension to 13% of the average wage, and by 2020 to no more than a tenth. In the words of Gal, the result will be 'a sharp reduction of the principal stable basis of income for old people' (Gal, 2003, p. 25).

In addition, the Oasis project and other researches in Israel and elsewhere have shown that younger age-groups give active support to their old, even at the expense of their own future economic situation

(Lowenstein & Daatland, 2006). In effect, the efforts of the young on behalf of the old will enable the young themselves to grow old without fear for the future. Binney and Estes claim that the expression 'generational equity' enables the government to shrug off its responsibility for individuals in need, and to transfer resources to sectors with high incomes. They suggest that the universal right of the individual to the satisfaction of basic human needs which the welfare system should supply throughout his/her life cycle should be taken into account (Binney & Estes, 1988).

Part B: Trends in Welfare Policy in Israel

Despite the complex situation described above, it may be said that, at a certain level, there are indications that in various spheres welfare policy in Israel has moved from the concept of intergenerational equity in the sense of generational obligation in the direction of a policy whereby old age is separated from the generation preceding or succeeding it. This situation can be described as 'lack of intergenerational obligation', or 'the beginning of the end of intergenerational justice'. We shall illustrate this trend by the use of two examples.

The Change from Funded to Private Pensions

Ensuring the social security of the ageing population is one of the most important challenges of social welfare policy. One of the ethical and moral principles which can be used to justify the social obligation to ensure the social security of the old and to resist the poverty which threatens to engulf them is the obligation of intergenerational justice. This argument is based on the supposition that when the younger generation is of working age it has 'enjoyed' – during the period of childhood and adolescence – the 'fruits' of the productivity and economic activity of those who are now old. Therefore, those 'young people' who have now matured and are able to work, should 'return' the benefits they have been given, and repay those who made it possible for them to grow and develop in a society with the resources for their education and training. The repayment for these benefits is also based on the assumption that in the future, when these 'young' people grow old, the coming generation, which is as yet unborn or in its infancy, will itself repay the present generation, and thereby close the circle of intergenerational reciprocity (Chen, 1998).

Traditionally, social security during old age, which was based on arrangements for funded pensions (also known as "pay-as-you-go" pensions), was based precisely on this supposition: the principle of intergenerational ethical and economic obligation. The reason for this is that the funded pension is so organized that the employer and employee do not contribute from current income to the fund for the future pension; and, therefore, the pension which is paid today to pensioners in work-places with funded pensions is, in effect, financed by the work, the produce and the services of those who are currently at work. In other words, in the system of funded pensions, today's workers are 'carrying on their shoulders' yesterday's workers. The reason they are prepared to do this is the knowledge and the promise that tomorrow's workers will 'carry' those of today. Again, it is the values of mutuality and continuity which enable the system to exist.

Of recent years, however, Israeli society has seen a significant retreat from the approach of the funded pension. As a result of recent economic emergency plans (although the general trend could already be discerned in the 1990s) it is no longer possible to join funded pension plans, and, in fact new workers in many parts of the economy in which funded pensions were the rule – such as the civil service or local authorities – have all been transferred to a system of private, defined-contribution (DC) pensions schemes (Doron, 2004; Pelleg, 2006).

Unlike a funded pension, private pension scheme is based on personal accounts, through which the worker and the employer each make payments directly to a pension fund, which manages each worker's pension separately at an individual level. The private DC pension has virtually very little direct connection with or dependence on intergenerational relationships, and there is practically little link or obligation between the different generations. Every generation and every individual has to care, for him/herself, in the framework of personal 'pension plans', independently of their colleagues, and whether or not they are of the same generation (Munnell, Sunden and Lidstone, 2002).

Although there are many reasons and arguments which led to the desire to bring the system of funded pensions to an end, there is no doubt that the ideological, political and ethical dimensions of the question of intergenerational relationships played an important part in Israel's readiness to adopt this change in policy. The adoption of a different set

of values concerning the relationships between the generations is far more than a simple 'technical' transition from one system to another.

The Raising of the Retirement Age

One of the classical arguments on the question of raising, and even abolition of the compulsory retirement age, is connected with the implications of the extension of working life on the level of unemployment, and the opportunities of the young to obtain work and promotion. One of the main reasons for the institution of compulsory retirement was the idea of refreshing the working force, and 'freeing' places of work for young people at the beginning of their path in life, so that they could advance their careers. Here again, just as in the case of the funded pension, it was assumed that old people would be prepared to cease working, even if they were able and willing to continue to work, as a result of their understanding that it is right and proper to do so in order to allow the younger generation to find work and develop their careers. Here, too, the basic assumption is that the old people of today 'profited' in their youth from the fact that veteran workers retired and vacated their places of employment (Shnit, 1978/9).

Just as in the case of funded pensions, here, too, over the past few years this concept has been eroded and resisted. An important expression of this is to be found in the amendment to the Law of Equal Opportunities of Employment, 1988, which was adopted in 1995. This amendment added 'age' to the provisions forbidding discrimination not only in recruiting workers but in a range of conditions of employment, promotion, wages and retirement. Another, no less important, expression was seen very recently, in the enactment of a law raising the age of compulsory retirement for men to 67, and for women, by stages, to 62 and then to 64. At a certain level it can be argued that the practical significance of this legislation is a reduction in the opportunities for employment and promotion of young people, as a result of the postponement of the retirement of the old. Clearly, this situation will become even more serious if this general trend persists and the American system, whereby compulsory retirement on the grounds of chronological age has been completely abolished, is adopted (Doron, 2004).

It would be possible to adduce more examples which appear to support the contention that one of the characteristics of social policy regarding the old has been the direct or indirect undermining of intergenerational obligations and relationships. Thus, for instance, a similar point could be made about the Law for Community-Based Nursing Care, 1988 which gives preference to formal instrumental care by salaried professionals over the informal care of relatives based on personal obligation (Borowski & Schmid, 2000); about the Patients' Rights Law 1996, which gives no preference or status to relatives in medical decisions about old patients who are no longer legally competent to make decisions about their own bodies; about the rescinding of tax credits for relatives who accommodate aged parents requiring constant care in their own homes and care for them; or even about the method in which various protective laws, such as the Law of Legal Competence and Guardianship, year which 'suspects' relatives of a conflict of interests in matters concerning the economic affairs of aged parents or relatives who are no longer of sound mind, are applied (Doron, 2004a).

Part C: Discussion and Conclusions

Each of the examples adduced above can be explained by economic or political considerations which are not necessarily linked with the complexity of intergenerational relationships. This is because each of the measures described above has been justified on the basis of economic reasoning, which ostensibly has no connection with intergenerational relationships or intergenerational justice. On the other hand, these developments can be interpreted in a much broader context of social ethics. If we are turning into a society in which the individual is the focus of attention, and the social groupings round him, such as the family, the community, or previous and succeeding generations, are irrelevant to the definition of his/her rights and duties, for old people this process means the abolition or severance of intergenerational relationships and obligations.

This trend is part of the general inclination to adopt the neo-liberal world outlook, with its exaltation of individualism and capitalism. But in concrete terms, this trend has special, and complex, implications for the old. On the one hand, this development can be viewed as a component of the 'liberation' or emancipation of the aged population from the historical 'bonds' which tied them in their relationships with

other generations. Old people are no longer economically dependent on the young of today; they no longer have to cease working against their will at the age of 65 in order to 'sacrifice' themselves for the benefit of the unemployed young; and they are no longer automatically 'abandoned' to the care and concern of their children or some other representative of the younger generation.

On the other hand, this development is open to criticism, and points to a number of shortcomings. When the young are 'freed' from the concern for or obligation to the old, how is it possible to ensure the functioning of social insurance programs intended to preclude poverty among those old people who have not succeeded in arranging a personal pension scheme for themselves? How will it be possible to prevent the steady erosion of the level of social benefits and social programs which support informal family care of the old – care which is the principal basis of support for frail old people with limited means who live within the community – at a time when the state increasingly shrugs off its responsibility, and lays it on the family?

Levin-Epstein's (2000) research data show that the family is in fact the main social framework for the distribution of resources in society. When the welfare state has difficulty in providing a universal safety network, the family becomes even more important. In this connection, the impact on weaker families is to some extent more serious; and this takes into account that there is proof of intergenerational continuity of inequality between the resources of the family of origin and the status of the families established by its children.

From many points of view, old people as a minority group are still dependent on combined political power with the younger generations in order to realize their legal rights. The cessation of this moral and social relationship will force them to fight independently in the political arena for their part in the attenuated aggregate of resources, while the forces arrayed against them are far stronger and more influential. In the final analysis this process will not bring about an improvement, but will weaken and impair the social and legal rights of the old in society.

The definition of policy questions in terms of generational equity leads to old people becoming scapegoats and being sacrificed to those who are interested in limiting the public sector and expanding

privatization. Generational equity means that all the generations in society should have equal levels of burdens and resources. Undoubtedly, there are difficulties in carrying out the contract for intergenerational transfers when the process of long-term justice has to be taken into account. None the less, the view that a person must insure his old age on his own account leads to privatization and a cut in expenditures. Further, the concept that it is impossible to continue to execute social programs because assets which are granted to a certain sector of the community are given 'at the expense' of the assets of another sector expresses a mistaken dichotomy which perpetuates class inequality between populations and erodes intergenerational obligations.

Issues for Discussion and Policy Recommendations

We have shown that generational equity is not necessarily the fundamental criterion for policy or fairness, and that it may be preferable to aim at the reduction of inequality between populations with low incomes and those with high incomes. In accordance with this approach, a number of central issues must be delineated if we are to continue the discussion and deal with policy-making:

1. The first major issue is whether the discussion should be based on a description of the competitive and conflictual relationships between different age-groups, or on an approach that emphasizes mutual dependence between generations.
2. A related issue is the question of whether a major criterion in policy-making should be generational equity or the aspiration to greater equality between weaker and stronger sections of the population.
3. The concept of the welfare state must be considered, since it is too a redistributory system, and can change the state of inequality between individuals and families to a certain extent.
4. It is important to examine the significance of the 'retreat' of the welfare state for the balance between the three above-mentioned systems – the welfare system, the labor market, and the family system. How is it that disturbance of this balance primarily influences the weaker social strata? Does this disturbance add even more to the significance of intergenerational equality or justice?

5. Another issue is the question of whether we should not also aim at equality in relation to private transfers – time and money invested by parents in their children – since the family is today the main mechanism for the transfer of care for children and the disabled.
6. Another central question is: do the monies paid to the National Insurance Institute, for instance for the financing of old-age pensions, constitute a tax with whose receipts the government can do what it wants, or does the payment by the workers ‘afford them rights’ over this money, on which they have learned to rely?

Regarding policy recommendations, according to the normative approach, it is important to strengthen intergenerational relationships and obligations, and to try to achieve a balance between the three systems – the market, the welfare system and the family.

The altruistic approach will advocate the development of a policy which will act directly on the variables which determine the behavior of the old person, such as fixing a low (subsidized) price for services, increased income, and direct provision of services, as well as the development of interventions which will work through their influence on the behavior of the offspring whose duty it is to care for a disabled parent: by granting tax reductions to increase their income, or by developing work friendly policies such as shortening their hours of work without reducing their income. In this way an adult child will receive a raise in income or payment for the hours in which [s]he assists her/his parent, on condition that [s]he is indeed an altruist who transfers resources to the parent. Intervention of this sort must take into account that parents and offspring constitute an economic unit which functions in accordance with its total resources, and the interventions will lead to a decline in transfers within the family.

According to the strategic approach, it is important to ensure a low price for services, additional income for the parent, direct supply of services, and added income for the adult child. Furthermore, it is important to encourage productive ageing, employment and involvement in the community as well as intergenerational programs such as ‘kindergarten grandpas’. It is important to develop a welfare policy based on a concept of the whole life course. Younger generations should be encouraged to make arrangements for their old age: to invest more

in private pensions and saving schemes, and, in parallel, to strengthen intergenerational ties on the basis of the concept of generational mutuality and mutual dependence, what has been termed the interdependence of generations (Attias-Donfut, 2003, 2005). From a life course perspective, it follows that an alternative formulation of generational equity is generational interdependence. Kingson, Hirshorn and Cornman (1986) discuss the “ties that bind” generations together and stress the high degree of inter-dependence between individuals and between generations within society. This view emphasizes what different generations have to offer one another as opposed to what one consumes at the expense of the other (Johnson, 2005).

Those who established the level of pensionable age did not consider the long years of leisure and their implications for intergenerational support and transfers. Therefore, it is important to reconsider the significance of egalitarianism, and to what extent it can be realized. The issues of retirement, financial transfers such as legacies, and the significance of two or three decades of life outside the labor system should be considered. It may be that we should consider the initiation of a flexible retirement age, between the ages of 55 and 75.

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Elder Abuse in a Cross-Cultural Context : Assessment, Policy and Practice

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ABSTRACT

The purpose of this paper is to examine the concept of elder abuse in a cross cultural context. Population aging is a global phenomenon. Mortality rates in most developing nations have declined faster than expected over the past two decades, with the result that many nations now have life expectancies approaching, or even exceeding, those of the developed nations. Practitioners often associate elder abuse with physical violence, but analysis of reported abuse in the United States demonstrates that financial abuse is more common. Although elder abuse is widespread it is often under reported as it is difficult to assess and prevent, especially in Asian communities in the United States and in South Asia. The case studies reflect elder abuse in the form of silent treatment, neglect, social isolation, and exploitation and are based on the first author's practice work. Strategies for assessment, intervention, and prevention are discussed.

Key words : Exploitation, Neglect, South Asian, Social isolation

With the global population of older persons expected to triple from 672 million in 2005 to 1.9 billion in 2050, it is becoming increasingly important to focus on policies and practices that support and enhance the wellbeing of the older population in later life. One sad reality for many seniors in later life and an increasing cause for concern is elder abuse. It is extremely difficult to exactly quantify the extent of elder abuse, neglect and exploitation because many such cases go undetected

and under-reported. According to a 1998 study, for every case of elder abuse that gets reported to authorities, about five more go unreported in the United States (National Center on Elder Abuse, 1998). Definitions of elder abuse vary as well. There are wide cultural variations in what gets considered as abuse both by the victim as well as the perpetrator. Further, there is no uniform reporting system because of which state level statistics vary widely and there is lack of comprehensive national level statistics in the United States as well as in other countries. According to the best available estimates, between 1 and 2 million Americans aged 65 and older have been injured, mistreated and exploited by people they depend on for protection and care (National Research Council, 2003)³. In the year 2000 alone, there have been 472,813 reports received on elder/adult mistreatment in various states in the US (NCEA, 2003). Almost 500,000 older people in the UK are abused every year (London Department of Health, 2000). The aging of populations with a shift away from institutional care in the developed world has increased demands on the family member for the care of the older person. This along with an uncertainty in the availability of health and social services could potentially increase elder abuse in the developed world. In the developing world too, increased longevity of the older population has created a strain on households with limited resources, particularly in the absence of formal social support systems. In countries that have introduced pension for older and retired adults such as Taiwan and South Africa, household compositions have changed that have left the older people vulnerable to potential exploitation. The consequences of elder abuse on the victim, perpetrator as well as families and communities are serious. Abuse can exacerbate chronic and disabling conditions of the older person and make the person more dependent, vulnerable and marginalized. For abusers, it may result in social rejection, broken family ties and embarrassment. Abusive workers are at risk for dismissal. Family members and communities lose out when the victim can no longer positively contribute and participate fully. All of this results in short run and long run financial costs to society. It has therefore become critical to understand the extent of prevalence of elder abuse, identify and mitigate the risk factors and provide prevention strategies to reduce incidences of elder abuse.

In this paper, we provide an assessment of what constitutes elder abuse in a cross-cultural context with a special focus on older South Asians living in the United States. We also discuss various prevention and intervention strategies to help mitigate incidences of elder abuse among this population.

II. What is Elder Abuse?

“Elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.” (National Center on Elder Abuse)⁴.

Elder abuse can be broadly categorized into self abuse, domestic elder abuse, and institutional elder abuse. Self abuse or self neglect is the result of the older persons' unwillingness to look after themselves as a result of depression from loss of spouse, loneliness, chronic pain, financial worry and loss of independence. Domestic and institutional abuse can be broken down into different categories: “

- **Physical Abuse** - Inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need.
- **Emotional Abuse** - Inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts.
- **Sexual Abuse** - Non-consensual sexual contact of any kind.
- **Exploitation** - Illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- **Neglect** - Refusal or failure by those responsible to provide food, shelter, health care or protection for a vulnerable elder.
- **Abandonment** - The desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.” (NCEA, 2008)

It is difficult to detect victims of abuse and both older men and women are at risk for being abused. Evidence from empirical and clinical studies confirms that a large proportion of elder abuse takes place in

shared living arrangements. Those who live alone are more prone to financial abuse. Further elder patients with dementia are at risk for physical abuse. Social isolation, pathological characteristics of perpetrators such as mental illness and alcoholism, and total dependency of the victim are other factors that lead to elder abuse (Lachs and Pillemer, 2004). Abuse of the elderly takes place in various settings including their homes, hospitals, assisted living facilities and nursing homes.

III. Theoretical Explanations of Elder Abuse

Various theories have been presented to explain elder abuse. Each of the explanations is not mutually exclusive in explaining causes of elder mistreatment because mistreatment results from multiple factors. Characteristics of the elderly victim and caregiver, and societal factors are the main causes of elder abuse.

1. Characteristics of the elderly victim

Demographic characteristics such as older age (such as those in the old-old category⁵), being female, being widowed, low income (Holt, 1994; Pritchard, 1993) and low educational attainment are associated with higher incidences of elder abuse. Further, total dependency as a result of disability, limitations in activities of daily living and dementia increases the risk of abuse.

2. Characteristics of the caregiver

Researchers have found that caregiver stress may lead to incidences of elder abuse (Phillips, 1983; Giordano & Giordano, 1984; Steinmetz 1983). Further, pathological conditions of the abuser in the form of poor impulse control, poor anger management, alcoholism are potential risk factors. The “learned violence” hypothesis (Gordon and Brill 2001) has explained that children who are maltreated or witness to violence are likely perpetrators of elder abuse. However, evidence for this hypothesis is weak.

3. Societal factors

Although the ‘modernization hypothesis’ has not been proven empirically, it is a factor that is used extensively to discuss elder abuse in developing countries or among immigrant populations that are in the process of a social transition. Kosberg and Garcia (1995) discuss the

socio-economic problems that stem from modernization and conclude that in modern society, the younger generation follows individualistic values, have geographic mobility and do not share the same values as their elderly parents. Some of the elderly parent-child relationship existing among immigrant Asian populations is based on social exchange whereby the younger generation supports the older adult financially and emotionally, in exchange of housekeeping or childcare services (Le, 1997).

It has been also argued that elderly who are tied to diverse social support networks are less likely to be abused compared to those in dense networks (Kosberg, 1988). The elderly that are part of a diverse network have a buffer from possible abuse as they have ties to both formal and informal support systems, hence the chances of abuse getting identified and reported is much higher.

IV. Incidence and Nature of Elder Abuse: Cross-Cultural Evidence

Although it is extremely hard to detect elder abuse, recent estimates of elder abuse in a variety of international settings are available from various sources. Studies with various sampling and survey methodologies have come up with a range of estimated frequency of elder abuse. A study of non-institutionalized elder in the metropolitan area of Boston, a frequency of 3.2 percent (Pillemer and Finkelhor, 1988), a national random sample survey from Canada measured that 4 percent reported maltreatment after reaching the age of 65 (Podneiks, 1992), a Dutch study measured elder abuse at a rate of 5.8 percent (Comijs, Pennix, Knipscheer, & Tileberg, 1999) while a study from Denmark and Sweden recorded a rate of 8 percent (Tornstarn, 1989). A study conducted to investigate elder abuse in residential settings in Sweden (Saveman et al, 1999) found that eleven percent of respondents who were nursing staff were aware of abusive incidents, and two percent admitted to abusive acts. Abusers were considered to be tired, burned out or short-tempered and the victims were mostly reported as mentally or physically handicapped and usually over 80 years old. The incidence rate of elder abuse from a study in Finland (Kivela, Kongas-Saviaro & Kesti, 1992) found that 3 percent of the men and 9 percent of the women interviewed indicated that they had been abused. The

most common types of abuse were physical and psychological, and the home was the most common place of occurrence. Patients of four Aged Care Assessment Teams in Perth, Brisbane, Sydney, and New South Wales in Australia were studied to assess prevalence and incidence of elder abuse. This study identified a 1.2 percent prevalence rate with psychological abuse as the most common form of mistreatment amongst this population (Kurrle, Sadler, Lockwood & Cameron, 1997).

Elder abuse was considered by the Japanese to be a "foreign" problem as late as 1987 and the subject still remains relatively invisible, with no elder abuse reporting agency in the country. A study (Tsukada 2001) using data from 1999 Nihon University Japanese Longitudinal Study of Aging to assess the awareness and perceptions of elder abuse indicated that only 51 percent of respondents were aware of elder abuse. In a study of 355 Hong Kong seniors (aged 65 and over), 21 percent of study participants were found to have experienced at least one instance of abuse (predominantly verbal abuse) within the past year (Yan & So-Kum, 2001). Researchers suspected that the Chinese tradition of preserving the privacy of the family may contribute to an underestimation of elder abuse. A study that explored the nature of elder abuse within the traditional Arab community (Sharon and Zoabi 1997) residing in Israel found an incidence rate of 2.53 percent for Arab elders. In urban areas, higher incidence rates were reported. While characteristics of abuse victims were similar to those in developed nations, a notable difference was that sons, rather than spouses, were found to be the most common perpetrators.

A study that examined the role of culture in the perception of various types of elder abuse showed that Americans found physical abuse to be more offensive whereas Koreans found psychological abuse as more offensive (Malley-Morrison, You, & Mills 2000). Hence, cultural factors impact perceptions of elder abuse and hence reporting of elder abuse.

Within a diverse country like the United States, there are substantial ethnic and cultural differences in the nature of elder abuse. In general, non-white ethnic elderly and recent immigrants are more prone to abuse. Studies focusing on Mexican-Americans who are the largest Latino population in America have found that elder mistreatment in the form

of denial of shelter (Sanchez 1998a). Normative *familismo* along with *vergüenza* (shame) is a barrier to reporting abuse and neglect amongst Latinos (Sanchez, 1998b). Financial exploitations, psychological intimidations, silence, avoidance and isolation are the main forms of elder abuse amongst Asian American communities such as those of Korean (Moon, 1998) and Vietnamese (Le, 1997) origin. The tendency to value family over individuals, fearing family shame, and avoiding conflict are the reasons for Asian elders' reluctance to seek formal services in addressing abuse.

In 2002, the World health Organization recognized the need to develop a global strategy to cope with elder abuse and working partnerships between the WHO Ageing and Life Course unit of the Department of Chronic Diseases and Health Promotion, the WHO Department of Injuries and Violence Prevention, the International Network for the Prevention of Elder Abuse (INPEA), HelpAge International and partners from academic institutions in a range of countries were envisioned to develop this strategy (WHO 2002). While most of the elder abuse literature has pointed to elder abuse as an individual and familial problem, hence an issue to be dealt within the family, the WHO report was the first to point out elder abuse as a societal problem, especially in the context of the developing world. Country reports were commissioned in Argentina, Brazil, India, Kenya and Lebanon and the emerging theme was the discomfort in talking about or acknowledging the presence of elder abuse. Particularly in India, 'abuse' was mostly understood as an extreme form of physical violence and its existence was denied. 'Abuse' supposedly did not exist but elder mistreatment was mostly construed as disrespect, loss of dignity, lack of emotional support and neglect by family members. Gender and socio-economic status were the key factors that led to elder abuse in India. Older, widowed and childless women were the most affected as well as those elders who were poor. Older persons in most of these countries, including India, blamed change in social roles, lack of governmental policies, and lack of health and social services as the real reasons for an increase in the incidences of elder abuse.

V. Abuse among South Asians living in the United States: How is it different ?

South Asian elderly constitute those who are 65 years or older originally from countries such as Bangladesh, Bhutan, India, Pakistan, Myanmar, Nepal and Sri Lanka. They constitute the third largest immigrant group in the United States growing at a rate of more than 100% over the last decade. This group is very diverse because of different languages, religions, food habits and socio-economic status. However, the common factor that binds this group together is the common cultural and social context of the Indian subcontinent (Diwan, Jonnalagadda, & Gupta, 2004). Respect for elders, financial and emotional support from sons in later life, and shared living with son's family are part of the social fabric (Gupta, 2002).

Psychological abuse, exploitation and neglect were found to be the main forms of abuse amongst South Asian seniors (Nagpaul, 1997; Pablo & Braun, 1997). Personal shame, family honor and protecting family members were main reasons for not reporting such experiences. In the course of practicing in the field, several cases of elder abuse were brought up in community meetings with the South Asian seniors in Dallas-Fort Worth area. The following case studies are illustrations of abuse among South Asian seniors (Gupta, 2005).

Case-1

Mrs. Y was 65 years old when she came to the US as her son and daughter-in-law were going to have a baby and they needed assistance with the new born. As soon as Mrs. Y came to the US she had to assume the responsibility of taking care of her newborn grandchild but also perform all the cooking and cleaning as her daughter in law went back to work after three weeks. All day Mrs. Y was confined to the house with the baby. Only on rare occasions did her son take her to the mosque. Mrs. Y felt lonely most of the time and would cry, as she felt like a prisoner. When Mrs. Y became sick and her stomach pain that did not subside after two months, her son sent her back home for a couple of months. Over the years Mrs. Y had lived in the US for more than 15 years. She was receiving Social Security Income and Medicaid. Mrs. Y's son would use the money she was receiving from the SSI for his own use. When Mrs. Y was sick her son would get some over-the-counter medication instead of taking her to a physician. Mrs. Y's son had also sold her home in Bangladesh, so when she felt

she was not becoming well and she wanted to go back but she did not have a place to go back to. Although her daughter and son-in-law were in a high income bracket yet they did not seek basic care for her but instead shipped her back. Within a few months Mrs. Y died as her stomach cancer was diagnosed at a much later stage.

Case-2

Mr. and Mrs. X came to the US as their son insisted that they would have a better life in the US. Within a few days of their arrival Mr. and Mrs. X were asked to do janitorial work as their son and his wife were motel owners. The elderly Mr. and Mrs. X had never cleaned toilets as they were mill owners in India. They felt demeaned having to do menial labor. Their daughter-in-law would verbally abuse them when some of the motel patrons complained about the dirty sheets. They wanted to go back, but their son would not let them. Each evening the older couple would sit alone to eat dinner as his son's family would eat early. Some of the time the older couple would go hungry as they were vegetarian and the son's family ate meat. One day when Mr. X asked his grandchildren some simple things like how to start the microwave, his grandchildren imitated his accent and laughed at him. A number of times Mrs. X would witness his grandchild and his girlfriend fooling around and when the older couple objected to this inappropriate behavior, they were verbally insulted. Over time Mrs. X had a stroke and Mr. X Parkinson's disease and he lost some of his hearing and sight and was unable to function at a fast pace. About two years ago the older couple was placed in a nursing home.

An attitude that is uniquely common among South Asian families is the ageist attitude that allows younger people to shun older adults. The latent belief among South Asians that *sathiyana* (sixtyishness), resulting in mentally unstable behaviors, forgetfulness, feelings of sadness, and physical limitations, is a normative part of the aging process convinces adult children against the necessity to get medical help for their elderly relatives. The lack of timely intervention prevents early initiation for treatment of chronic diseases such as diabetes, heart disease and cancer. This ageist attitude is one of the causes of perpetuation of prejudice and neglect of older adults. Some South Asian elderly are reluctant to seek physical and mental health services because they feel like a burden on their adult children.

VI. Strategies for Prevention of Abuse amongst the South Asian Elderly Population

Prevention of abuse is a three stage approach. Primary prevention measures include promoting awareness about elder abuse as well as providing services to protect elders against abuse. For example, primary prevention strategies include using governmental agencies for creating awareness and advocating for elderly who are at risk of being abused, providing services to strengthen caregiver and elderly person's interpersonal skills, manage conflict, and confer other relationship and life skills to foster emotional resiliency. These services are provided for the most part, by health professionals and public health agencies.

In addition, the elderly need to be educated about their legal rights, safety, and the effect of abuse on health and mental health. Confidential telephone hotlines in ethnic languages should be provided so that the elderly have a voice to express their concerns. As one of the main reasons for elder abuse is caregiver stress (Gupta, 1999), overnight relief with nursing care and adult day services need to be created within the community that would provide respite for the caregivers. Encouraging medical professionals such as physicians, nurses and social workers to provide primary care services through free weekly clinics, improving health literacy through Health Fairs are other primary prevention strategies.

The goal of secondary prevention is to identify elder abuse in its earliest stages, before noticeable symptoms develop, and when it is most likely to be treated successfully. With early detection and diagnosis, it may be possible to prevent elder abuse. Secondary prevention also aims to prevent the spread of elder abuse. Early identification and treatment of victims of elder abuse, not only provides secondary prevention for those who are abused but also primary prevention for those who are potential victims.

Like primary prevention, individual health care practitioners, public health agencies and non-governmental organizations perform secondary prevention. Physical and mental health screenings to identify elders at the risk of abuse, and identifying stressed and emotionally unstable caregivers are some of the secondary prevention strategies. Hospitals, medical clinics, and physicians play an important role in secondary

prevention where they can often conduct screenings and detect abusive relationships in their earliest stages. Table 1 contains a guide to the various signs and symptoms of elder abuse identified by Action on Elder Abuse (2007).

Table 1 : Signs and Symptoms of Elder abuse

Physical Abuse

The older person has Untreated injuries that are in various stages of healing or are not properly treated including cuts, lacerations, puncture or open wounds, bruises, welts, discoloration, burns, bone fracture or breaks;

Has poor skin condition or hygiene;

Shows signs of dehydration, malnutrition or weight loss that are unrelated to illness;

Has soiled clothing including bedclothes;

Reports having been hit, slapped, kicked or mistreated;

Shows signs such as broken eyeglasses or having been punished, or having been restrained;

Shows signs of having used medication inappropriately, including signs of overdose or under dose.

Psychological Abuse

The older person Shows signs of helplessness, confusion or disorientation, emotional upset or agitation, unexplained fear or anger without apparent cause;

Claims verbal or emotional abuse;

Displays sudden changes in behavior or unusual behavior such as sucking, biting or rocking;

Denies situations or tells implausible stories;

Hesitates to talk openly;

Shows sign of extreme withdrawal, a lack of response and communication.

Neglect

The older person Has poor personal hygiene or rashes or sores or lice;

Has inadequate clothing;

Shows signs of dehydration, malnutrition or untreated medical conditions;

Shows signs of over or under medicated;

Lacks assistance when eating or drinking.

Familial abuse

The older person Is forbidden to speak for him or herself or from seeing others when alone;

Is the object of indifference, anger or aggressive behavior such as threats, insults or harassment or is blamed inappropriately for example for being incontinent;

Is isolated from other family members or is restricted from being fully active or shows signs of unusual confinement;

Offers accounts of incidents that differ from those of family members;

Shows signs of having lacked assistance or attendance.

Financial Abuse

Signatures on the older person's checks do not resemble those of the older person's or signed when the older person cannot write;

There is a sudden change in the older person's bank account, including unexplained withdrawal by others or the addition of new names, or there is an unexplained sudden transfer of assets from the older person to family members or others;

There are unexplained disappearances of funds or valuable possessions from the older person;

There is an abrupt change in or a sudden establishment of the older person's will;

Previously uninvolved related appeal suddenly to claim an interest in the older person's affairs or unusual concern is expressed by family members or others about the amount spent on the older person's care;

The older person has numerous unpaid bills or overdue rent, when there are supposed to have been paid by others;

The older person lacks affordable amenities such as personal grooming items or appropriate clothing;

The older person is deliberately isolated from friends and family, giving caregivers full control.

Source: Adapted from Box 1 in Gerard Cronin, "Elder abuse: the same old story", *Emergency Nurse*, vol 15 no 3 (2007).

Unlike primary and secondary prevention, tertiary prevention involves actual treatment for both the elderly victim and the caregiver. Elders who are admitted to the hospital for physical injuries as well as elders participating in community events can be checked for signs and symptoms of elder abuse. A thorough needs assessment of the older person would be crucial. The practitioner should create a supportive environment where the elder feels safe to disclose information about being abused. The practitioner also needs to obtain information about health status, mental health and behavioral problems of the older person. After assessing the emotional stability of the caregiver, history of violence in the family, availability of support network of extended family and friends, the family members should be approached separately to get a comprehensive picture about the dynamics of family functioning. While making an assessment clinicians and practitioners need to be culturally sensitive to understand elder abuse within various ethnicities, cultures and language groups. Tertiary prevention measures also include outreach programs that monitor older vulnerable persons who live in

the community to ensure that their needs are being met by their caregivers. Such programs have demonstrated efficacy in reducing elder abuse.

Practitioners and physicians are mandated by law to report elder abuse. It is not necessary that the report of abuse come directly from the victim or abuser for it to be considered valid. A report from the third party who suspects abuse can be sufficient (Welfel, Danzinger, & Santoro, 2000). Failure to report can result in a misdemeanor or in some states the license to practice might be revoked. In an institutional setting elder abuse can be prevented if relatives and family members of the nursing home residents become eyes and ears, not only for their loved one, but also report abuse when they witness psychological, physical or verbal abuse meted out to another resident.

According to a 2005 report by American Bar Association Commission on Law and Aging (NCEA, 2008), there are three categories of laws that protect elder abuse in the United States: adult protective services, institutional abuse and the long term care ombudsman program. Criminal laws and other laws in a jurisdiction may also authorize services for older abused persons. For example, in instances of physical abuse, domestic violence laws with tools such as restraining orders can be invoked to help older adults. Further, regulations and policies as well as power of attorney and state laws on guardianship are important for elder abuse. Although federal laws for domestic violence and child abuse fund programs and shelters for victims, there are no comparable laws on elder abuse. The federal Older Americans Act provides definitions for elder abuse and authorizes the National Center on Elder Abuse as well as supports some state-level programs and activities. However, it does not fund services and shelters for abused older persons.

The Adult Protective Services Laws have helped establish a system of reporting and investigation of elder abuse and provide services for helping and sustaining the victims. All fifty states and territories of the United States have enacted legislation authorizing adult protective services (APS) to deal with elder abuse. State APS laws vary widely regarding age of eligibility, type and location of abuse, reporting (mandatory or voluntary), investigation procedures and remedies.

In some states such as Georgia, Delaware and Illinois amongst others, separate laws address elder abuse and mistreatment in institutions and have agencies other than APS deal with these cases. Some other states such as California and New York do not make any distinctions between domestic and institutional abuse and places all cases under the jurisdiction of APS agencies. Currently, all but five states mandate reporting suspected abuse. The states that do not require mandatory reporting are Colorado, North and South Dakota, Pennsylvania and Wisconsin (NCEA, 2008). In all states the older person can refuse protective services.

Additionally, all states have laws authorizing the Long Term Care Ombudsman Program (LTCOP) which is mandatory for states to institute in order to receive federal funds. The LTCOP acts as an advocate for long term care residents, who experience abusive situations, refer these cases to the APS or other agency, local law enforcement agency or the agency responsible for licensing the long term care facility. Sometimes, LTCOP fulfills the APS function and has the legal authority to carry out an investigation in response to reports of abuse in a long term care facility.

At this stage of intervention where the practitioner reports abuse, the elderly may be removed from the private home and placed in a residential facility. Many older adults wish to remain in their homes even after being abused. Therefore service providers need to intervene with both the victim and the abusive caregiver. Abusive caregivers need to be held accountable for their inappropriate behaviors (Schwiebert, Myers, & Dice, 2000) and assisted in confronting the root cause so that the cycle of abuse could be broken. If the abusive behavior of caregivers cannot be changed, the older person needs to be removed to a safe place.

Other ways to stop abusive behaviors of family members and caregivers is by educating them about the services that are available to them (Quinn & Tomita, 1997). Assistance to caregivers are available in the form of respite care, volunteer visitors programs, books and videos on how to perform care giving tasks, support groups and various other existing community resources. Treatment of conflict, strain, depression, anxiety, anger issues can also help to mitigate abusive behavior (Reay and Browne, 2002).

VII. Other Suggested Community Level Interventions

The most common form of intervention is psychological treatment that includes family therapy, individual therapy and relationship counseling that requires behavioral skills training, cognitive restructuring and emotional impulse control (Papadopoulos & Lafontaine, 2000). Caregivers of the elder need to be empowered by recognizing that they need personal time, assistance like respite care, education and guidance on how to deal with behavior problems of the elderly. Positive reminiscence is a technique that can be used effectively as it entails enhancing compassion and attachment between the adult child caregiver and the elderly (Browne & Herbert, 1997). Intervention also needs to address depression, sadness, shame and guilt experienced by victims of elder abuse.

Intervention strategies should focus on enhancing and supporting the strengths and survival skills of victims. For example, South Asian elders formed a seniors group at the local Hindu temple where they would meet once a month for a Senior citizen meeting. At these meetings, the seniors would decide whether they should have picnics, celebrate holidays together, and plan off-season international travel. Some of the seniors raised enough money to have small houses built near the temple so that they could live independently. Seniors who knew English found part-time jobs which assisted them in having some discretionary money. Other older South Asians designed a day care so that young couples could leave their young children in their care.

Psycho-educational seminars need to be conducted in the community that are aimed at educating both elderly and potential or current caregivers regarding the factors and challenges involved with care-giving and the possibility of abuse. Information on the challenges involved in becoming a caregiver of elderly parents, of available social support services including health services should be easily accessible. The social context has to be understood before encouraging parents to immigrate to a new country.

At the community level affordable housing for older adults, foster care, group living should be offered as a substitute for family care. It is important that family caregivers are able to access in-home support

services, adult day care, and senior centers with recreational activities. Social support networks for both the elderly and the caregivers are needed to lessen the incidences of elder abuse and neglect. Informal support groups can be started so that caregivers can share ideas that will assist them in venting and releasing tension. An added advantage is that such support groups may help them in pooling resources and providing relief to each other.

VIII. Conclusion

Each year hundreds of thousands of older persons are abused, neglected, and exploited by family members and others in the United States. The victimized are often people who are frail, helpless, and vulnerable and depend on others to meet their basic needs. Legislatures in all 50 states have passed some form of elder abuse prevention laws. Laws and definitions of terms vary considerably from one state to another, but all states have established reporting systems. Generally, Adult Protective Services (APS) agencies receive and investigate reports of suspected elder abuse. The 2004 Survey of State Adult Protective Services, funded by the Administration on Aging, found that there was a 19.7 percent increase from 2000 to 2004 in the total cases of elder and vulnerable adult abuse and neglect, and a 15.6 percent increase in substantiated cases. Twenty states reported that more than two in five victims (42.8 percent) were aged 80 years or older. Most alleged perpetrators in 2003 were adult children (32.6 percent), followed by other family members (21.5 percent) and spouses/intimate partners (11.3 percent) in 11 states that reported older abuse.

Unlike the long history of successful legislation in the US on domestic abuse and child abuse, legislation around prevention of elder abuse has been fraught with failure. Therefore without any assistance from the federal government, the states made their own laws and reporting procedures⁶. Out of 52 states, about 17 used more than one type of law to address elder abuse. For example California used its own elder abuse reporting laws. Other states like Georgia, Missouri and Oregon had laws protecting the elderly against abuse in long term care facilities only. Many parts of the US were not able to identify and devise laws to respond to elder maltreatment for lack of funds. After decades of failed legislation and denial of funding to the states, the

Congress using the Family Violence Prevention and Services Act of 1992 (P.L. 102-295), mandated a national study of the incidence of neglect, abuse and exploitation of elderly people (NEAIS, 1998). The Administration of Children and Families (AF) joined forces with Administration on Aging (AoA) and jointly funded the National Center on Elder Abuse (NCEA) which is a national resource center dedicated to prevention of elder abuse. Since there is a lack of uniformity in the policy and practice of elder abuse prevention in the United States, it is even more important for community level efforts to recognize and encourage elder abuse awareness in a culturally sensitive context.

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Resolving Elder Abuse Complaints in Homes for the Aged : Relevance of Ombudsman Program**Varsha Pandya**

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ABSTRACT

The paper provides information on the Ombudsman program in the US and other European countries for the consideration of Indian stakeholders in the development of Homes for the aged. The article also provides alternative models, processes and potential pitfalls of these to guide the decision making for the program development similar to the ombudsman programme in India.

Keywords: Ombudsman Program, Homes for aged, Indian Context, Destitutes.

Homes for the aged whose family may not be able to provide care for them are a growing phenomenon in India. The internet exploration showed the listing of homes for the aged in four southern states of Kerala, Tamilnadu, Karnataka, Andhra Pradesh and the City of Delhi (List of old age homes, retrieved 02/07/08). It is believed that the growth of such homes in these states is because of increased migration of the younger generation in pursuit of better economic opportunities compared to other states. Karmayog (retrieved on February 7, 2008) detailed the four types of old age homes in Maharashtra based on monthly charges : (1) Old people without any support – Free, (2) Based on the income of elderly persons, (3) Charging less than Rs.1000/- per month, (4) Charging more than Rs.1000/-per month. According to Roy (no date), the government of India has initiated the setting up of 603 old age homes for India's 21 million destitute who

are 60 years and older - one in each district of the country. The Ministry of Social Justice and Empowerment will provide a grant of Rs.20 million to state governments for constructing each home that would accommodate not less than 150 destitute senior citizens.

Sawhney (no date) reports that the traditional belief that the elderly are well taken care of in a joint family system is quickly becoming a myth as shown by some cases and ethnographic studies. These studies found that even though the elderly may be living with their son's family, sometimes their needs are neglected. Old age homes are set-up for elderly members who do not have appropriate caregivers immediately available and who cannot care for themselves. The guiding principle for these homes in India is to provide an opportunity to such elders to spend the "evening of their lives" with dignity and respect (Sawhney, no date, p. 11).

Concerned citizens, gerontology professionals, and the government needs to take proactive steps to address the issues related to sub-standard care, neglect of residents, and possible abuse that are likely to occur in growing numbers of homes for the aged (HfA) in India. In western countries, where residential care facilities for older adults have existed for more than four decades, the maltreatment of elders in these facilities was observed in a variety of forms that compromised human dignity and worth. These included serious neglect of physical care required, overmedication, unnecessary use of restraints, and verbal, physical, sexual, and financial abuse (Monk, Kaye, & Litwin, 1984). Wilson (1978) observed that the residents whose rights are curtailed or who have been victims of abuse and neglect in residential facilities often times did not come forward to complain and seek justice and restoration because of their frailty, isolation from the community and families, lack of physical and psychological energy for combativeness required in the face of adversarial relationship that might result in HfA, lack of financial resources and legal assistance, and small value on injury to those in the evening of their life. A study done by Gottsman and Bourestom (1974, as cited in Monk *et al.*, 1984) confirmed a positive relationship between the rate of visitors in such facilities and quality of care provided to its residents. Ombudsmen, who are third party visitors with certain investigative, advocating, and reconciliatory resolution

powers, have been adopted as a fairly successful mechanism in the western world to address the violation of bill of rights and abuse of residents of HfA.

The objective of this paper is to provide information on the Ombudsman program for consideration of Indian entities that might be interested in developing a proactive system to address the potential issues of elder abuse and maltreatment in HfA. Monk *et al.* (1984), though an old reference, have been frequently used in this paper for the comprehensiveness of the information and that it was written during the times when Ombudsman programs were still in the developmental stages in the United States.

What is an Ombudsman Program ?

An Ombudsman Program is assigned responsibility to investigate complaints made by or on behalf of older persons in long-term care facilities or HfA (Lehigh county office of Aging and Adult Services, n.d.). The Ombudsman also assists in resolution of the substantiated complaints. This is the minimum role that an ombudsman is required to play; but there are several other responsibilities that an ombudsman program can be assigned and tasks that its staff or volunteers may perform.

Models of Ombudsman Program

Monk *et al.* (1984) identify three models of Ombudsman program: classical, executive and hybrid.

Classical : This model was developed in the Scandinavian countries in late 19th and early 20th centuries to investigate complaints against the administration. An independent, non-partisan office of the legislature was assigned the task to investigate complaints from the public against administrative injustice and maladministration. This office had power to investigate, criticize, and publicize, but not to reverse any administrative action.

Executive : The Ombudsman is an appointed officer by the executive branch of the government who develops and oversees a system to receive, investigate, and dispose complaints received from or on behalf of the residents in HfA.

Hybrid : The Ombudsman in this model is a specialist employed within a system, (e.g., prison, hospital, HfA) who acts as a mediator

between the consumer (client), community, and the system. The person attempts to see all sides of the dispute and bring it to a satisfactory and reconciliatory resolution.

Besides these models, there are three systemic designs found in literature (e.g., Monk *et al.*): salaried professionals only, volunteers only, and a mix of salaried ombudsmen and volunteers. Three types of functions that ombudsmen can carry out investigating, advocating for the residents, and liaising between the community, HfA, and the oversight authority in the government. Though all types of ombudsman programs are found to be useful in resolving complaints in HfA, there are certain disadvantages associated with each of these designs and expectations placed on Ombudsmen. Certain tasks have an inherent conflict. A partisan (one advocating for the resident) ombudsman may be biased when investigating a complaint. Certain investigative tasks may be vulnerable to fallacy should the matter go to the judicial system. A volunteer ombudsman may not have the needed specialized knowledge to investigate complaints related to over-medication, unnecessary restraints, or other lapses in professional care and victimization. On one hand, the ombudsman program may find it difficult to demand accountability from volunteers who may just leave. On the other hand, the ombudsman employed in the system may not be non-partial in the investigation of the complaints.

An alternative "Board of visitors" model comprising of family and friends of the residents and community leaders also can be found in literature (Monk *et al.*, 1984). A pilot of such a board had investigative and some judicial powers in all complaints of elder abuse in HfA. The board was able to subpoena the witnesses and record their testimony under oath, as well as require production of documents relevant to investigation. The findings of such boards were systematically noted and were, in most instances accurate and substantive. The major drawback however was that such a board did not have any sanctioning power, and oftentimes authorities ignored their findings, minimizing their work as "not professional", "done by volunteers" and burying their reports without instituting pertinent changes and sanctioning the persons responsible or guilty of offending against the elder resident (Monk *et al.*, 1984).

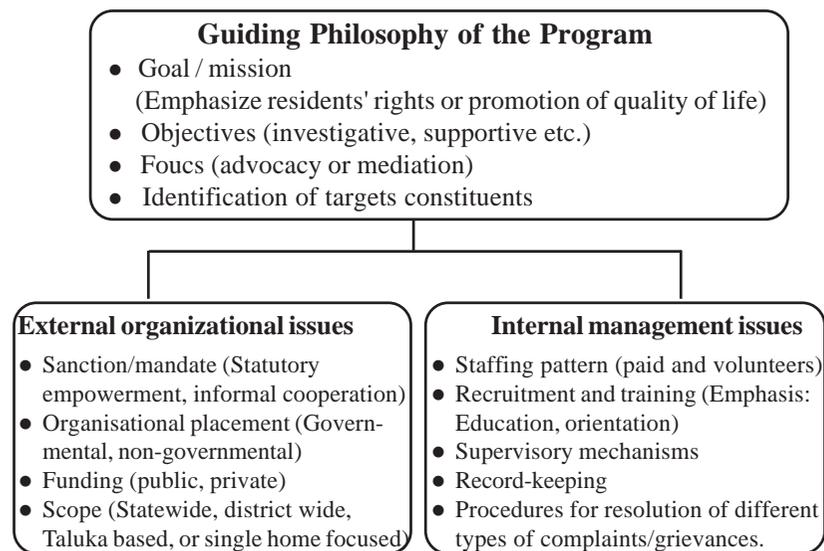
The U. S. Ombudsman Program

The Ombudsman program in the U.S. began as a demonstration program in 1972 and is currently established in all states of the U.S. under the Older Americans Act, administered by the Administration on Aging (AoA). In the year 2000 there were about 1000 paid and 8000 certified volunteer ombudsmen (Administration on Aging, retrieved 03/13/08). The U.S. adopted the executive model of Ombudsman program, using a mix of staffed employees and volunteers, where volunteers are trained and certified to carry out all the three functions of investigator, advocate, and community liaison (AoA, retrieved 03/13/08; Monk *et al.*, 1984). It must be noted though that there are variations in the program structure and function in different states because the executive powers to implement the Ombudsman program is vested in the states (AoA, n.d., American Association of Retired persons [AARP], n.d.). Several national studies (e.g. Monk *et al.*, 1984, Pearson, 2004) identified roles performed by Ombudsmen across the country. The paid Ombudsman staff generally performed the role of training and supervising volunteer ombudsmen, assisting them in conducting investigation, and serving as a liaison between the volunteers, residential facility administrators and the oversight agency of the government. The volunteers identified their primary role as being friendly visitors to the residential facilities with empathy for the residents. Some volunteers saw their role as a mediator when the residents had grievances whereas some identified themselves as advocates for the residents (Pearson, 2004). Resident abuse cases, when substantiated were then referred to the appropriate governmental or judicial authorities for their resolution whereas ombudsman could mediate, advocate and resolve issues related to violation of the residents' rights, discrimination in health care, mental health needs, relationship issues, and participation in the governance of the facility. Monk *et al.* (1984) reported several tasks assigned to the ombudsman program across the states, which can also be found in more recent literature available on the AoA and AARP websites (see additional resources in the reference section). These tasks are (1) to establish a better relationship between the HfA and the community to facilitate informal oversight that can prevent isolation of the residents and prevent abuse of residents; (2) to facilitate involvement of the residents and their family and friends in the governance of the facility;

(3) to establish a mechanism for speedy resolution of residents' complaints; (4) to file a complaint on behalf of the residents or their families when they cannot do so; (5) to provide public education on long-term care; and (6) to provide information to legislature and program planners for needed changes in policies and programs for the long-term care of the elderly.

Monk *et al.* (1984) studied issues that different Ombudsmen programs considered for the development of their own programs. Based on their findings, they suggested a model pathway for program development that may be considered by decision-makers in India if they choose to develop an Ombudsmen type of program. Figure 1 outlines some of the issues that may be considered for the development of Ombudsman type of program in countries like India where HfA as a mainstream care giving mechanism for elderly is a more recent phenomenon. As is evident in the chart, issues are identified from the literature on program administration and management whereas details of each issue are picked out from the specific discussion about the program I have presented so far in this paper. The next section discusses the issues in implementation process of the Ombudsman program.

Figure 1: Issues for Program Development



Issues in Implementation of Ombudsman Program

The issues in implementation of Ombudsman program are mainly identified from the experience of Pennsylvania state report where the author currently resides. But as the readers will note these issues can be generalized to any situation wanting to design and implement such a program. First and foremost, the issue of housing of the ombudsman office must be decided. Having the office of the paid executive of the program in appropriate department of the state government will provide the much needed decision-making and sanctioning authority to the program. This executive can supervise paid employees at district offices or can contract with non-governmental organizations (NGO) to execute the tasks and responsibilities of the ombudsman program at the district level. Whether an employee of the government or an NGO, mechanisms, procedures and processes for investigation, intervention, and resolution must be clearly stated and adequate decision-making and sanctioning authority be vested in a district level or even Taluka level officer. A clear guideline must be developed about what routes for resolution may be used under what types of situations or findings: litigation route, mediation and collaborative corrective action route, or dismissal of the complaint. Depending on what route is chosen, who will be best trained to play that role effectively? An advisory board comprising of multidisciplinary experts (e.g., lawyer, social worker, psychologist, physician etc.) to provide the needed guidance during the process of investigation and resolution can be very effective.

Pennsylvania Advocates for Better Care (1979) reported the usefulness of an advisory committee during the development years of the Ombudsman program. The board had 50% membership of allied professionals (Physicians, nurses, social workers, lawyers, etc.) and 50 % membership of consumers, citizens and service providers (representatives of residents, family members, HfA administrators and staff, and community leaders). The advisory committee was found to be very useful in diffusing conflicts, devise creative solutions to problems, and assistance in the development of educational material. The only, but important limitation observed was the minority representation of consumers on such advisory committees. The

consumers' voice was generally overpowered by the service providers and the allied professionals. The report recommended increasing representation of the consumers on such a committee.

Complaint Resolution Procedures

Oftentimes the residents do not complain because either they are incapacitated or they feel vulnerable and powerless, or both (Huber, Borders, Netting, & Nelson, 2001; Monk *et al.*, 1984, Pennsylvania Advocates for Better Care, 1979; Walshe, 2001). Huber et al (2001) found in their study that even when a complaint was made on behalf of the vulnerable population like members of the racial minority groups, a lower percentage of those were resolved compared to the complaints received on behalf of the racial majority group. Indians should also be cognizant of this fact and ensure that the poor, women, and persons from the scheduled castes, tribes, and lower castes are treated fairly in HfA. Huber *et al.* (2001) also found that men were more vulnerable to physical abuse and women were more vulnerable to sexual abuse in HfA.

There are three ways in which an Ombudsman can note complaints. One, when the Ombudsman visits HfA, the residents can tell him about the difficulties they are experiencing; two, other people may call the ombudsman to lodge a complaint; three, during the visit the ombudsman may notice an abusive situation or violation of patients' rights or compromised care of a resident, and may note a complaint. Some complaints the ombudsman may be able to resolve at the facility level either through mediation between the aggrieved party and the accused party or by involving the advisory committee. Other complaints, once verified or substantiated, may need referral to the health department, prosecutor's office, or another relevant agency. When the complaint is referred elsewhere for its resolution the ombudsmen office may keep the case open and monitor its progress or may close the case (Huber *et al.*, 2001) after that agency becomes actively involved.

It is important to determine the maximum time limit within which the verification of the complaint must be completed and a disposition determined. Besides, if hiring volunteers, Linnane (1977) and Monk *et al.* (1984) suggest that emphasis may be put on training the ombudsman

on the following skills: developing a macro-micro view of the presenting problem, investigative skills, interviewing skills, tact, firmness, knowledge of government and ability to work through bureaucracies, patience, conflict resolution, mediation, advocacy, ability to listen to many sides and make an objective assessment, ability to solve a problem, and a sense of humor. Keith (2000), in a survey of volunteer ombudsmen training, found that the availability of training and certification to become and ombudsman volunteer in the communities were more effective in recruitment, retention, and effectiveness of volunteer ombudsman than the in-service training provided after recruiting the volunteers. The former attracted those individuals who saw volunteerism as their second career. The findings of the study of Keith also suggested that volunteer ombudsmen preferred access to written manuals and other references and resources that could help them understand the needs of older people in HfA, and successfully carry out their roles. Ombudsmen also preferred that more time was allotted to hands-on experience that provided opportunities for them to learn and practice the skills and techniques required by their responsibilities and tasks. They also expressed a need for attending conferences and workshops for continuing education as well as interaction with other ombudsmen.

Concluding Remarks

Due to the growing number of homes for the aged in India, a clear need to prevent and address elder neglect and abuse in these homes is established. Ombudsman programs in the U.S. and European countries provide a framework for the Indian stakeholders in development of Homes for the Aged to meet this need. In my opinion, questioning the need for such a program is not up for debate here, but the question "what type of responsive program does India want to have to address this potential problem of neglect and abuse in homes for the aged" definitely needs to be asked. The article provides alternative models, processes, and potential pitfalls of these to guide the decision-making for the program development similar to the Ombudsman program in India. Training and employment of paraprofessional work force instead of voluntary ombudsmen may be worth considering for the Indian situation. It is hoped that such a process will be prompted or enhanced as a result of this writing.

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- Additional Resources:
- American Association of Retired Persons: www.aarp.org
- Administration on Aging, U.S.: <http://www.aoa.gov>
- National Long Term Care Ombudsman Resource Center, U. S.: www.nccnhr.org
- Locating State Ombudsman program: <http://www.ltcombudsman.org/>

The Abuse of Older People : The English Scenario

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ABSTRACT

This article provides an overview of the problem in the U.K. The various types and aspects of abuse are outlined and approach to handle the suspected cases of abuse discussed. Various international guidelines are mentioned and the last U.K. Government actions are presented. The crucial need for more research in the field is emphasized. Also the importance of ongoing in scientific educational training for professionals and carers is highlighted. A number of regulatory measures recently taken by the U.K. authorities are mentioned. Most importantly the need for an attitudinal change to old age will be of paramount importance.

Key words: Granny, Battery, WHO (Toronto) Declarations, Human Rights Issues, U.K. Organization, Abuse in Dementia.

Whilst the mal-treatment and abuse of children are very well recognised attracting lots of public and media attention, mistreatment and neglect of older vulnerable individuals do not usually arouse the full interest and attention of the society at large. Only extreme cases are reported in the newspapers as incidents of a criminal nature.

Unfortunately there is a paucity of high quality research in this field and, as such, anecdotes abound. As far as my recollection goes Dr Geoffrey Burston, a Bristol Geriatrician had reported in the British Medical Journal the first case of 'Granny Battering' in this country, frustrated carers being blamed for this (Burston G, BMJ 1975; 3, 592). The descriptive title was chosen presumably to compare

it with 'baby battering', i.e., abuse of children. In the last 3 decades, there have been many enquiries, reports, guidelines and advisory legislations; the general attitude of the community as a whole, however, hasn't altered all that much; the alleged 'incidents' are still not taken seriously and often remain un-investigated and un-actioned.

The abuse of the older people has been defined by the WHO (2002) in their Toronto Declaration, for International usage, as

'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'

Although this is a good starting point, unfortunately the emerging picture is much more complex than that; furthermore this definition doesn't include 'neglect' i.e., failure of provision of basic necessities for survival: food, heat, hygiene and APPROPRIATE HEALTH CARE (CORRECT DIAGNOSIS and TREATMENT OF PROVEN VALUE). Human Rights issues do come into this as well.

The overall qualities of research in this field, as mentioned already, have not been of the highest order in both their depth and expanse. The study undertaken by Ogg & Bennett (1992) in conjunction with the OPCS Omnibus survey had looked only at the 65-74 year age group living in the community and detected abuse of various types: physical in 2%, financial in 2% and verbal in 5%. It had been extrapolated that at any one time, about 500000 older people in this country are being abused in some form. Unfortunately this study hadn't included more frail and also mentally infirm elderly residents of care homes and hospitals; accordingly no definitive conclusion on the incidence of elder-abuse could be drawn. In another study published a bit earlier (Garner & Evans, 2000) in each year approximately 1000 cases of 'abuse' were said to be reported to the UK Central Council of Nursing consisting of verbal, physical and sexual nature. In 2003, an enquiry among the District Nurses revealed that 88% of them had encountered some form of abuse in their professional contacts (Potter, 2003). More recently (2004) the UK Dept. of Health enquiry into total referrals for 'adult protection cases' established that nearly 30% of such cases related to older subjects. To summarise the situation, therefore, the true incidence of elder abuse in own homes, care homes and in hospitals

remains largely unknown; hopefully the current 'Protection of Vulnerable Adults (POVA) 'scheme launched by the Govt.(DOH, 2000) would shed further light and 'protect' the vulnerable from the perpetrators.

One of the main difficulties in these issues affecting the old and the vulnerable seems to be a general lack of public awareness intermixed with an element of 'dismissiveness'. Whilst abuse of children attracts wide attention, publicity and a very tight regulatory approach, there is nothing yet, similar to those targeting the old. Other forms of domestic violence also receive a significant degree of public interest, even production of movies, e.g., *Provoked*, with famous Bollywood stars! Perhaps this reflects the overall social attitude to ageing; the old, unless rich, still remain undervalued.

There is a feeling in this country that the people in the East are much more respectful towards their elders and the old are treated with dignity. I am currently not adequately qualified to comment on this. Sadly one reads the odd sad tales of 'neglect' of the old in Indian newspapers from time to time. It is important that further social and socio-medical research and surveys are undertaken to measure the true incidence of this evil practice in India.

Another important factor is training or the lack of it. In the UK, Geriatric Medicine and Nursing are established 'specialist' areas; even then, many 'trained' people remain appallingly ignorant and ill-prepared on 'abuse' cases. Handling of 'suspected' cases tends to be amateurish. Assessment is inadequate and fragmented and follow up poor.

To tackle the situation more thoroughly, the health-care establishment is now setting up a variety of measures on the assessment process, further management protocols and most importantly, a proper infra-structure with a protection co-ordinator in each district. Health care agencies are now being directed not to appoint any one with a poor record, to the services for older people. Such employee screening has been applicable to child-care areas for many years.

Guidelines are being issued with regular training sessions involving all categories of health and social care professionals and care staff. Police authorities are beginning to show an interest and hopefully in

another few years, good and effective multi-disciplinary protection teams will be fully operational in all the health districts.

From the existing experience, the principal 'risks' tend to remain with –

People living with others (e.g., spouse or relatives) are more vulnerable to verbal and physical types; people living alone are more likely to be at financial risk.

Individuals with dementing illnesses and behavioural disorders are more likely to be abused physically.

Abuse of all types are commoner in the socially isolated.

As regards the perpetrators, those who 'financially depend' on the older person, frequently under the influence of alcohol or drugs or are mentally unstable themselves, are more likely to be abusive. Despite 'frustration and tiredness', ordinary carer-stress has not been found to be a cause of abusive behaviour.

For a 'prevention' strategy, such risk factors are extremely important and should be identified, and corrective measures taken at an early stage, before it is too late.

Recognition of any form of abuse is not always easy. Whether the bruises are due to recurrent falls or from physical abuse, can be a bit tricky to establish, against 'denials' from many corners. Verbal berating, psychological pressure, financial misappropriation, etc., need to be explored by a properly experienced and trained multi-disciplinary team of professionals. When the 'culprit' happens to be the only available support for the frail old person, it is unlikely that the 'victim' would speak out! The doctor can't do it alone. Clinical interest and involvement along with a degree of leadership from the family doctors, however, is very useful and, therefore, to be encouraged.

In this country, a number of well-organized charities are doing sterling work in the field; the best known specialized organization is 'Action on Elder Abuse' (www.elderabuse.org.uk). A close look at their official website would provide detailed information about their activities on training, research, service provision needs, programmes for seminars, networking with other similar organizations both in this

country and abroad, etc. They are probably the most authoritative source of information in this country at this moment. Other age-charities, e.g., Age Concern (www.ageconcern.org.uk) and Help the Aged (www.helptheaged.org.uk) also have experts to advise on the subject. The specialist medical body 'British Geriatrics Society' has a 'policy' statement (Compendium of Guidelines; BGS, 2007) on elder-abuse, updated every 3 years (www.bgs.org.uk). The reader is advised to look at these web sites for further detailed information which cannot possibly be all provided in a small article such as this.

Elder abuse is beginning to be recognized in this country, as an entity warranting proper attention of the local statutory agencies and the national government (DOH, 2000). This process has commenced but will not be fully operational overnight. The media and public interest will be a driving force and everyone will be watching. Whether the incidence of elder-abuse will increase is difficult to predict as its causation happens to be multi factorial intermixed with many social and health care issues (Fox *et al.*, 2007)

There is enormous scope for both medical and social research. The south Asian community of the very first generation immigrants are now in their old age. New research into the pattern and incidence of abuse in that cohort of population would be very useful when assessing their service needs. A comparative study of such occurrences in the older folks in the subcontinent and those living abroad, would be very interesting. Let's hope this special issue of IJG will stimulate such interest among its readers.

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Determinants of Elder Abuse in Rajshahi City Corporation, Bangladesh: Evidence from a Micro-Level Survey

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ABSTRACT

Although family ties in Bangladesh are still strong and an overwhelming majority of the old live with family members, nevertheless the position of an increasing number of older persons is becoming vulnerable. In the present scenario they cannot take it for granted that their children will look after them when they need care in their old age in view of longevity, which implies an extended period of dependency. There has been little research on elder abuse in Bangladesh. The frightening finding is that in Rajshahi City Corporation there are 17% abused elderly. The study shows that most of the abused elderly were young old. Females who were widow and illiterate were more vulnerable to abuse. The overall finding of this study also seems to suggest a close relationship of abuse with family head, physical condition, living arrangements and educational background and this piece of information needs to be scientifically utilized in developing suitable programs addressing the elderly in country. The researcher emphasizes the importance of replicating this research, and incorporating culture specific findings into customized intervention strategies.

Keywords: Elder abuse, Poverty, Dependency, Physical illness, Widow

Data regarding elder abuse are difficult to find and interpret because elder abuse is a relatively recently recognized phenomenon, has a wide variety of definitions from state to state, and is subject to cultural interpretation (Wolf, 1997). According to National Centre on Elder Abuse (NCEA) (2008), elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. The specificity of laws varies from state to state, but broadly defined, abuse may be: (1) **physical abuse** - inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need, (2) **emotional abuse** - inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, (3) **sexual abuse** - non-consensual sexual contact of any kind, (4) **exploitation** - illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder, (5) **neglect** - refusal or failure by those responsible to provide food, shelter, health care or protection for a vulnerable elder and (6) **abandonment** - the desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.

Elder abuse may be domestic, taking place in the home of the abused or in the home of a caregiver, or it may be institutional, taking place in a residential facility for the elderly (e.g., a nursing home). Elder abuse may be intentional (active) or unintentional (passive) (Wolf, 1997). Physical abuse is only one among many subtypes of elder abuse, which includes psychologic abuse, financial abuse, sexual abuse, and neglect. Although these subtypes are discrete entities, they are often closely related and interdependent. In an extensive study, neglect was found to be the most common form of abuse, followed by psychological abuse, financial exploitation, physical abuse, abandonment, and sexual abuse. In the home, two thirds of abusers are spouses and adult children (AOA, 1998).

Many characteristics of the perpetrator and the victim have been cited as potential risk factors for elder abuse. A shared living arrangement lends itself to an increased risk of abuse due to the proximity of the abused and the abuser, and greater risk has been noted if the patient

resides with immediate family but without a spouse (Pavesa, et. al., 1992). Characteristics of the perpetrator that increase the risk of abuse include a history of mental illness, substance abuse, or dependence on the victim for financial assistance, housing or other needs (Pillemer, 1988). Perception of stress by the caregiver, not the stress level, was correlated with increased abuse (Wolf, 1997). Characteristics of the elder, including frailty, poor health, and functional impairments, have been shown to be associated with an increased probability of mistreatment, although these data are controversial (Wolf, 1997; Lachs, et. al., 1997). An elder's aggressive behavior toward caregivers has been shown to increase the probability of physical abuse (Pavesa et. al., 1992). Elderly persons most susceptible to neglect were those in poorer health, more socially isolated and without contacts to call for help (Pillemer, 1988).

In the advanced countries, studies have shown that most elderly are neither safe nor happy at home as well as in institutional setting (Pillemer and Tinkelhor, 1987; Koserg and Gracia, 1995). It was during 1980's that elder abuse gained rapid recognition in U.S.A. and U.K. It is estimated that in every year around 0.5 to 2.5 million elderly are subjected to physical violence alone in U.S.A. We lack such statistics for Bangladesh. Thus this study makes an attempt to determine the important factors of elder abuse and neglect in Rajshahi City Corporation, Bangladesh.

Materials and Methods

The study is based on the data of 87 abused persons out of 495 persons aged 60 years and over who were purposively interviewed in Rajshahi City Corporation during September 6, 2008 to September 16, 2008.

We found three types of abuse – mental, economical and physical in the study area. A score was developed to measure how much percent an elder was abused. Firstly mental abuse is scored 1, economical abuse is scored 2 and physical abuse is scored 3. So, the total score was 6. Then each score was divided by the total score and multiplied

by 100. Thus on this basis if an elder was mentally abused, it was scored 16%, if economically then 33% and so on. Point bi-serial correlation was used to investigate the relationship between the causes of abuse (according to the respondent's statement) and the score. And finally the score was used as a dependent variable to determine the important factors related to elderly abuse by analysis of variance named as General Linear Model (GLM) Univariate Analysis of Variance.

Salient Features

Before presenting the major findings of the study an account of the societal characteristics of the respondents may be in order. Table 1 presents the data in this regard.

Table 1 shows that majority of the abused elderly are young old, i.e., between 60-69 years. This is somewhat contradictory to the prevailing view, which suggests that oldest of the old are the most vulnerable group who receive ill treatment. This unexpected result can be explained by the fact that many oldest elderly respondents possibly felt ashamed of or became embarrassed to admit their ill-treatment openly even to their next door neighbours. Or, may be, they were too afraid to disclose their woes and miseries because of the fear of being thrown out or abandoned.

Female elderly who were widowed are more susceptible to ill treatment as 80% of them reported to have suffered from abusive behaviour while the corresponding figure for male elderly is 16.2% only. Since the life expectancy for females is higher than that of males and age at marriage for females is less than that of males, more males exist in married status after 60+ years than females.

The study revealed that four-fifth of the abused female elderly were illiterate and most of the study respondents were Muslim.

Data also show that half of the abused elderly lived with married children. Relatively more female than male abused elderly lived alone. About two-third of the family were male headed and only one-third family's monthly income was more than 5000 takas.

Table 1 : Demographic and socio-economic characteristics of the respondents

Characteristics	Male		Female		Total	
	Freq.	%age	Freq.	%age	Freq.	%age
Age group (in years)						
Young Old (60-69)	24	64.9	40	80.0	64	73.6
Adult Old (70-79)	6	16.2	5	10.0	11	12.6
Oldest old (80+)	7	18.9	5	10.0	12	13.8
Marital Status						
Married	30	81.1	9	18.0	2	2.3
Unmarried	1	2.7	1	2.0	39	44.8
Widowed/Widower	6	16.2	40	80.0	46	52.9
Educational Qualification						
Illiterate	13	35.1	40	80.0	53	60.9
Literate	24	64.9	10	20.0	34	39.1
Religion						
Islam	35	94.6	48	96.0	83	95.4
Hindu	2	5.4	2	4.0	4	4.6
Living Arrangements						
Living alone	4	10.8	15	30.0	19	21.8
Living with spouse	9	24.3	2	4.0	11	12.6
Living with unmarried children	5	13.5	8	16.0	13	14.9
Living with married children	19	51.4	24	48.0	43	49.4
Living with others	-	-	1	2.0	1	1.1
Family Head						
Male	32	86.5	30	60.0	62	71.3
Female	5	13.5	20	40.0	25	28.7
Family Income						
≥ 2500	9	24.3	25	50.0	34	39.1
2501 – 5000	11	29.7	14	28.0	25	28.7
5001+	17	45.9	11	22.0	28	32.2
Total	37	100.0	50	100.0	87	100.0

Physical Conditions and Causes behind Elder Abuse

Table 2 shows the self stated physical conditions and causes behind elder abuse. According to the study respondents, 48% female elderly were unhealthy while the corresponding figure for male was 21.6%. Approximately 67% abused had been suffering from some disease or the other during the 6 months before the survey.

Table 2 also revealed the view points for being abused. According to the abused elderly, the causes behind the abuse were mainly poverty, inability to do any thing and dependency. They also identified property distribution to the children and their physical illness as causes for getting abusive behaviour.

Table 2 : Self stated physical conditions and reasons for abuse

Characteristics	Male		Female		Total	
	Freq.	%age	Freq.	%age	Freq.	%age
Present Physical Condition						
Healthy	13	35.1	9	18.0	22	25.3
Fairly healthy	16	43.2	17	34.0	33	37.9
Unhealthy	8	21.6	24	48.0	32	36.8
Suffered from Some Disease During Last 6 Months						
No	13	35.1	16	32.0	29	33.3
Yes	24	64.9	34	68.0	58	66.7
Reasons For Abuse ——— Poverty						
No	18	48.6	15	30.0	33	37.9
Yes	19	51.4	35	70.0	54	62.1
Reasons For Abuse ——— Inability						
No	22	59.5	28	56.0	50	57.5
Yes	15	40.5	22	44.0	37	42.5
Reasons For Abuse ——— Dependency						
No	33	89.2	23	46.0	56	64.4
Yes	4	10.8	27	54.0	31	35.6
Reasons For Abuse ——— Property Distribution						
No	35	94.6	46	92.0	81	93.1
Yes	2	5.4	4	8.0	6	6.9
Reasons For Abuse ——— Illness						
No	33	89.2	47	94.0	80	92.0
Yes	4	10.8	3	6.0	7	8.0
Total	37	100.0	50	100.0	87	100.0

Correlation between Score and Reasons for Elder Abuse

Though we observed the cause of elder abuse according to the study respondents in table 2, in order to find out the degree of the relationship between score (non-dichotomous) and the reasons (dichotomous), point bi-serial correlation was used (See Table3)..

Table 3 : Correlation analysis between score and the reasons of elder abuse

Reasons	Score		
	Male	Female	Total
Poverty	+0.02 (0.937816)	+0.2 (0.504491)	+0.13 (0.675498)
Inability	-0.27 (0.417363)	-0.15 (0.620129)	-0.19 (0.541560)
Dependency	-0.62 (0.042601)	+0 (0.992200)	-0.29 (0.343451)
Property Distribution	-0.52 (0.100496)	-0.41 (0.149505)	-0.45 (0.109241)
Illness	-0.54 (0.067508)	-0.43 (0.124853)	-0.46 (0.097033)

Notes: Parenthesis indicates the p-value

From table 3 we observed that score is positively related with poverty but negatively with other reasons for all respondents except the dependency for female elderly. Remarkably, we found dependency and illness for male and illnesses for total respondents are significantly related with the score of elder abuse.

Determinants of Elder Abuse: Application of GLM Univariate Analysis of variance

Considering the score of elder abuse as dependent variable and Q12, Q30, Q37 and Q38 as covariates we determine the factors important for elder abuse where Q4 is treated as random factor and Q10 as fixed factor. The results are presented in table 4, 5 and 6 for male, female and total respondents respectively.

The more important findings from table 4 revealed that family headship, present physical condition and the interaction between living arrangement and educational qualification of the elder are significantly related with elder abuse i.e., score of elder abuse. But we did not get any significant factor for female elder abuse in table 5. In table 6, for total elderly we again found that interaction between living arrangement and educational qualification is a significant factor for elder abuse. In addition we identified suffering from any disease during the six months before the survey as an important factor for elder abuse for total respondents.

Table 4 : Tests of between-subjects effects for male dependent Variable: SCORE

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	
Intercept						
Hypothesis	29.664	1	29.664	0.118	0.735	
Error	4499.476	17.873	251.744			
Q12	Hypothesis	2790.907	1	2790.907	11.234	0.004
	Error	3975.000	16	248.438		
Q30	Hypothesis	11.523	1	11.523	0.046	0.832
	Error	3975.000	16	248.438		
Q37	Hypothesis	915.442	1	915.442	3.685	0.073
	Error	3975.000	16	248.438		
Q38	Hypothesis	22.785	1	22.785	0.092	0.766
	Error	3975.000	16	248.438		
Q10	Hypothesis	4073.090	3	1357.697	2.368	0.186
	Error	2909.663	5.075	573.351		
Q4	Hypothesis	2772.991	9	308.110	0.507	0.821
	Error	2839.821	4.669	608.241		
Q10 * Q4	Hypothesis	2757.546	4	689.387	2.775	0.063
	Error	3975.000	16	248.438		

Notes: Q4 = educational qualification, Q10 = living arrangements, Q12 = family head, Q30 family's monthly income, Q37 = present physical condition, Q38 = suffer from any disease during last 6 months.

**Table 5 : Tests of Between-Subjects Effects for female
Dependent Variable: SCORE**

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	Hypothesis	1118.064	1	1118.064	4.906	0.035
	Error	6646.901	29.165	227.910		
Q12	Hypothesis	.653	1	.653	0.003	0.956
	Error	7346.190	35	209.891		
Q30	Hypothesis	160.494	1	160.494	0.765	0.388
	Error	7346.190	35	209.891		
Q37	Hypothesis	44.266	1	44.266	0.211	0.649
	Error	7346.190	35	209.891		
Q38	Hypothesis	121.797	1	121.797	0.580	0.451
	Error	7346.190	35	209.891		
Q10	Hypothesis	5201.520	4	1300.380	2.279	0.372
	Error	888.543	1.558	570.489		
Q4	Hypothesis	1719.716	4	429.929	0.876	0.599
	Error	933.131	1.902	490.682		
Q10 * Q4	Hypothesis	949.768	2	474.884	2.263	0.119
	Error	7346.190	35	209.891		

**Table 6 : Tests of Between-Subjects Effects for total
Dependent Variable: SCORE**

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	Hypothesis	1709.106	1	1709.106	6.640	0.012
	Error	18301.687	71.104	257.395		
Q12	Hypothesis	409.946	1	409.946	1.613	0.209
	Error	15248.048	60	254.134		
Q30	Hypothesis	25.517	1	25.517	0.100	0.752
	Error	15248.048	60	254.134		
Q37	Hypothesis	2.591	1	2.591	0.010	0.920
	Error	15248.048	60	254.134		
Q38	Hypothesis	813.880	1	813.880	3.203	0.079
	Error	15248.048	60	254.134		
Q10	Hypothesis	4985.188	4	1246.297	2.270	0.140

	Error	4990.304	9.090	548.978		
Q4	Hypothesis	2459.806	11	223.619	0.438	0.905
	Error	5290.982	10.366	510.414		
Q10*Q4	Hypothesis	4593.657	7	656.237	2.582	0.021
	Error	15248.048	60	254.134		

Conclusion and Policy Recommendations

Though most of the abuse will remain unreported because people are too frightened, ashamed or embarrassed to bring it to light, we found out that 87 abused elderly out of 495 aged 60+ years i.e. 17 per cent. It was also found that most of the abused elderly were young old. Females who were widows and illiterate were more vulnerable to abuse.

It is obvious from the study that elder abuse has to be taken as an urgent issue. The overall finding seems to suggest a close relationship of abuse with the family head, his physical condition, living arrangements and educational background and this piece of information needs to be scientifically utilized in developing suitable programs addressing the elderly in the country. The government really needs to introduce various social packages for the elderly, apart from increasing the literacy level and employment opportunities for the aged, making the older persons real assets rather than liabilities.

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Critical Understanding of Prevalence of Elder Abuse and the Combating Strategies with Specific Reference to India

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ABSTRACT

'Elder abuse' has only recently been a subject worthy of serious academic inquiry and concerted action in India. However, absence of valid statistics and systematic collection of facts related to the problem contribute to it being still under-recognized and insufficiently acknowledged. Lack of conceptual and definitional clarity as well as under-reporting comes in the way of finding ways and means to combat it. Understanding abuse of older people and finding solutions to deal with it are further complicated by social taboo among older people on discussing the subject and consistent denial by family members that abuse takes place in their homes. Also, from the legal discourse angle is the difficulty that not all of the situations characterized as abuse fit into existing legal categories. Consequently, little attention is being given to elder abuse as a major social issue. Even less effort is being devoted to tackling the underlying causes of elder abuse and developing appropriate interventions and adopting combating strategies. This paper reviews prevalence of elder abuse and its combating strategies in the Indian context based on the author's research, academic interest and engagement with the subject as an activist.

Key words : Causes of Elder Abuse, Major Social Issue, Interventions, Combating Strategies, Indian Context.

In India, as in many other developing countries, traditionally the responsibility of taking care of older persons and protecting them, falls

on individuals in the family and the community. Yet, family and community are now increasingly being viewed as shying away from their role of 'caring for elders' and are being held responsible for perpetuating elder abuse, neglect and violence, even though defining these words is controversial. Indeed, there is no consensus about the definition of 'elder abuse'. Its meaning is still rather obscure with regard to its forms and the settings in which it occurs.

Many families, certain community and religious leaders as well as politicians claim that while occasional neglect of older people and crime against them may occur in Indian society, or old parents may at times be disrespected, but historically and at present there is no substantial evidence to treat 'abuse' of old parents and elders in the family and the community as a major social problem. They argue that 'elder abuse' equated with very violent physical behavior is a concept associated with 'western societies'. It is asserted that, 'abuse' is a strong word for behavior or action that does not generally happen to older people in 'our' society, in 'our' families and communities as there is practice of taking care of elders by families - near and distant, or religious bodies, philanthropic individuals, charitable agencies and government as well as community based organizations (WHO, 2002; Shankardass, 2003 [b]).

In fact there is a history of old age homes, *ashrams* (residential place provided by a religious or philanthropic group for individuals without family members), in other words, there are institutions which provide care to older people when it is non available from kith and kin (Shankardass, 2000). In general, as is often stated in public discourses, Indians show reverence to older people implicitly or explicitly in various ways, despite certain plays, films, and fiction over the years depicting neglect of older parents by sons, daughters-in-law, even daughters and grand children.

There is also the recent legislation promoted by the government, namely the 'The Maintenance and Welfare of Parents and Senior Citizens Bill' which provides an understanding of 'elder abuse' in the Indian context, without actually defining it. The legislation, popularly called as the Maintenance Bill, was approved by the Cabinet in December 2007. It is viewed as a social welfare mechanism to protect adults, parents and "senior citizens", defined as 60 years of age or

older. It refers to the challenges being posed in society in the context of care of the growing number of older people and the declining ability of families, communities and governments to deal with the issues. It views neglect of older people as a concern and its understanding in terms of mistreatment is similar to that voiced by the World Health Organization (WHO, 2002), where it is seen as a manifestation of the timeless phenomenon of inter-personal violence, but only now in the 21st century is it achieving due recognition. Clearly, perceptions and definitions of abuse/neglect of older persons and violence against them vary in time and place and between groups across and within families, communities, classes and societies.

Understanding through Definitions, Typology & Contextualization

Report of the Secretary General of United Nations on Abuse of Older Persons (2002) submitted to the Commission for Social Development which acted as the preparatory committee for Second World Assembly on Ageing stated that there is lack of clear and transposable definitions in both developed and developing countries. Yet, there is global evidence of abuse of older persons based on studies conducted in the past 20 years. There is documentation of older people's perception and experience of abuse which encompasses neglect, violence, maltreatment, exploitation, deprivation, abandonment, etc., though there is deficiency of reliable and valid data and also there are shortcomings of methodology in documentation. Nonetheless, internationally growing attention to human rights and increasing awareness of the rights of older men and women have led to viewing abuse of older persons as a human rights issue, a framework appropriate to view elder abuse as a political, economic, social and health concern requiring adequate and effective combating strategies. Indeed, older persons' vulnerability to abuse may increase when their rights as guaranteed in international covenants and embodied in the United Nations Principles for Older Persons are violated. Thus if older persons', independence, participation, care, self-fulfilment and dignity is hampered and they are denied choices and opportunities, then indications of abusive practices against older people are prevalent and we need to document it by establishing valid and robust definitions which provide a better knowledge base for developing strategies to combat it.

Significantly, 'elder abuse' as a term does not find place in the dictionary. But, due to concern with issues of care of older persons, and probably because of growing evidence of abuse of older persons the term 'elder care' has gained popularity and is getting included as a specific new agenda in policies and programs across the countries. In 2004, Oxford, the most trusted name in references, included 'elder care' in its publication on 'New Words'. This is a volume of record of words for which no dictionary at hand provides any help. But, due to public comprehension of words, they survive, gain importance and get defined by lexicographers as a response to changes in human activities over a period of time (Hargraves, 2004). Preoccupation of our times with care of older people and rather growing lack of it resulting in abuse/neglect of older people gives recognition to the word 'elder care' in the context of its usage and general currency across the world. It sets the ground for outlining the rights of older people in matters of their independence, participation, care, self-fulfilment and dignity, i.e., the UN Principles for Older Persons.

In India, as in many other parts of the world, there is growing evidence that 'elder care' defined in the Dictionary of New Words as "care of the elderly or infirm, provided by residential institutions, by paid daily help in the home, or by family members" is increasingly lacking or is inadequate and inappropriate. As few studies conducted since the 1990s, the years since when the subject started to receive substantial research attention (Padmasree, 1991; Mahajan, 1992; Shah *et al*, 1995; Bambawale, 1996, 1997; Vaithi, 1996; Dandekar, 1997; Ushasree & Basha, 1999; Bakshi, 2000; Mehta, 2000; Bose and Shankardass, 2004, Puri, 2004; Shankardass, 2002, 2003 [a] & [b], 2004) and my on going research on older people residing in institutions and at home indicates that often their health, emotional, financial and social needs are not met and consequently they feel neglected, abandoned, disrespected, maltreated, threatened, exploited and emotionally blackmailed.

The recent legislation 'The Maintenance and Welfare of Parents and Senior Citizens Bill', is also based on the premise that there may be children, biological or adopted or grand children who fail in caring for their aged parent/grandparent (GoI, 2007). The Bill strives for

ensuring financial, emotional and social security to the 'uncared' senior citizens by their families (Shankardass, 2007). The Maintenance Bill which was in its formulating stage termed as 'The Older Persons (Maintenance, Care and Health) Bill' observed that even if parents are residing with children, recent trends of erosion of values of respect for senior citizens, changing roles and life styles at the household and work level, shortage of space in residential dwellings in urban areas, and emergence of greater emphasis on 'individualism' by the children, is leading to severance of family ties and parents being deprived of their culturally accepted dependency on children, resulting in growing financial and social insecurity among the older people (GoI, 2005). The National Policy on Older Persons announced in 1999 also acknowledged these changes which are leading to a number of senior citizens being left to live alone, with insufficient resources to meet even their most basic requirements of food, clothing, housing and medical care.

The Oxford Dictionary (2006) defines 'abuse' as treatment with cruelty or violence, for a bad purpose, addressing in an insulting and offensive way. Other dictionaries, for instance, Webster's include in the meaning of abuse also reproach, to disparage a person in the most violent terms, to take unfair or undue advantage of, to injure, hurt and damage and treat without consideration or fairness, to be physically harmful and maltreat. Clearly, the ever present face of violence, both overt and covert, physical and non-physical, generally associated with abuse of women and children, now also has overwhelming influence on our understanding of abuse of older people. 'Neglect' in contrast is seen as careless behavior resulting in failure to give proper attention to care, which may result in isolation and social exclusion without any strong social censure. This may include self neglect, a set of behaviors that threaten the health and safety of an older person and lead to limited capacity for self care and health seeking behavior. Significantly, the legislation 'The Maintenance and Welfare of Parents and Senior Citizens Bill', intends to protect adults, parents and "senior citizens" from neglect by their children (GoI, 2007), but does not mention the term abuse. Also, while it outlines besides families the role of old age homes and hospitals in providing for elderly care, the Bill does not consider the possibility of institutional abuse, which is increasingly being associated with institutional care provisions in countries where it is available.

A typology of elder abuse that has gained ground universally, identifies four categories of abuse, namely, physical; emotional; financial exploitation; and neglect (Tatara, 1995; United Nations, 2002; WHO/INPEA, 2002). In recent times, sexual abuse, spousal abuse and medication abuse have been expanded in the typology (Shankardass, 1997; Ushasree & Basha, 1999, DWARF, 2002, 2003). Scientific literature recognizes also other specific forms of elder abuse, primarily, loss of respect, scapegoating – identifying and blaming older people, usually women, for ills befalling the community. In India and in many other third world countries incidents have been reported about older women, generally widows being ostracized, tortured, maimed or even killed in order to gain control over their assets (Shankardass, 2003 [b]; Puri, 2007).

Development agenda (United Nations, 1995), in particular, voices the need for identifying also systemic abuse as a form of elder abuse in so far as there is marginalization of older persons in institutions, or by social and economic policies and their implementation, and leads to inequitable resource allocation and discrimination in service provisions and delivery. This form of abuse becomes specifically significant with reference to ageing societies such as India.

In the first ever united work on elder abuse undertaken by the international community including World Health Organization (WHO), International Network for Prevention of Elder Abuse (INPEA), HelpAge International and researchers, scholars from academic institutions in a range of countries, namely Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden it is recognized that elder abuse is perceived by older people under three broad areas – (1) Neglect including isolation, abandonment and social exclusion; (2) Violation of human, legal and medical rights; and (3) Deprivation of choices, decisions, status, finances and respect. All of this in some form or the other occurs in both developing and developed countries across the continents.

Recent studies on marginalization of older people have also documented instances of elder neglect and abuse emerging from political violence, armed conflict, displacement, disasters and emergencies, whereby needs of older people are rarely provided for in relief plans

and rehabilitation programs. A review of recent disaster management programs in India indicated that during earthquakes and tsunami higher proportions of older people were left out from aid provisions as few agencies at the national and community level included them in the target population for assistance (Shankardass, 2005). Significantly, the 11th Five Year Plan as part of its development agenda identifies an inclusive approach and notes the vulnerability of older people along with other groups, which require special attention.

United Nations, after taking into account variations in the definition of elder abuse among the member countries adopts an approach based on the 'British Charity Action on Abuse of Older Persons' which reads as "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" (United Nations, 2002). The critical level of defining elder abuse in such a manner lies in the socio-cultural understanding of its experience both at the level of the individual and the social group. Importantly, the break down of "trust" can occur within family, community and institutional settings, through social interactions, contractual relationships or those established even with intruders. Such an understanding facilitates recognition of elder abuse in diverse forms as economic, social, community and political violence against older people, provided greater attention is paid to its manifestations. Recognition of indicators and manifest effects of abuse are essential for detecting elder abuse, which in turn reveals its prevalence.

Detection Necessary for Understanding Prevalence

While theoretically abuse can be easily classified in terms of neglect, violation and deprivation, the problem in understanding it comes when we try to identify its occurrence, relate it with the reporting mechanisms and seek justice for the grieved party. The question arises, what kind of behavior and action can be termed as abuse and how can it be detected, given the variability of factors in providing care, such as poverty, lack of education and awareness of old age problems, economic and social constraints. Gender inequality and structural disadvantages seen in many developing societies, including India add another aspect which requires consideration in our understanding of prevalence of

elder abuse. Further, if we include certain societal forms of deprivations and violations of rights associated with older persons without governments and communities and at times older persons themselves perceiving them as abuse, we confront terminological confusion.

Problems with detecting 'elder abuse' relates to lack of clarity about its definition and this arises from the fact that in our country the issue is still under recognized and not sufficiently acknowledged as a societal concern. For any consensus on the definition, it is essential that 'elder abuse' be first recognized as a social problem of significance. In the UK and European countries, reference to the problem of elder abuse started to appear around the 1970s (Burston, 1975), and later through the seminal work of Eastman Mervyn (1984) the issue received attention for developing socio-political and legislative action to tackle abuse. In America, even though little legislative attention has been paid to the social problem of elder abuse at the federal level (Brownell, 2003), there exists some amount of terminological understanding. It is defined in terms of its physical, financial or psychological impact (Wolf & Pillemer, 1984), as mistreatment (Hudson, 1989) or active even passive neglect or self neglect. In Australia, abuse and neglect of older people by family members started and soon there was a confirmation of it as a social, medical and legal problem in both residential care and the community (Kurrle, 2003).

In India, as per review of research studies, articles and books, 'elder abuse' as an academic concern started to surface in the 1990s though as a subject worthy of serious inquiry and concerted action it has begun to receive attention only at the turn to the 21st century when the rapidly growing numbers and proportions of older persons in the populations are gradually being acknowledged as a significant group having rights, requiring care, services and programs for living a life of dignity and respect (Shankardass, 2003 [b]).

In India, as it is in all other societies too, elder abuse is difficult to document and quantify since it occurs primarily in the privacy of the home. Reporting system for elder abuse was almost absent till recently. The Police as its drive to combat crime against older people have improved mechanisms to report and record cases of elder abuse and neglect. The Maintenance Bill gives power to third party to report neglect

of older people and the Tribunals set up to deal with maintenance issues can take action without any plea from the victims of such neglect.

In terms of neglect of older people, elder abuse and violence against older persons, invariably it is seen that while neglect gets ignored by the concerned parties (Shankardass, 2003 [a], [b]), abuse and violence against older people 'may become known to authorities through a third party' (Mahajan and Madhurima, 1995). But, by and large, cases of abuse have often gone unnoticed and unreported, with only the most severe cases commanding attention. There is no mandatory mechanism to report mistreatment, neglect or abuse of older people in Indian society unlike in some western countries. Older people are reluctant to speak of their trauma of violence, abuse and neglect and a concern with the family's reputation coupled with dependence on those who may be abusive and violent but supposedly responsible for taking care restricts them from acknowledging it publicly, especially in the case of women and those living in institutions. In fact, those experiencing and observing it remain generally silent and indifferent. Researchers have faced difficulties in discussing the subject with respondents as often there is persistent denial by family members that abuse takes place in their homes. Many people deny its existence, or camouflage it with other terms considered to be less severe. As a result there is absence of valid statistics and systematic collection of facts related to the problem. The limited studies conducted are small scale, thus there is inadequate documentation notwithstanding lack of conceptual and definitional clarity. Definitional dispute about what may constitute abuse is linked to the fact of its obscurity. Consequently, it is difficult to accurately measure the national extent of the problem.

How Prevailing is the Problem

Based on certain studies on elder abuse conducted in India UN Secretary General in the Report presented at the Second World Assembly (United Nations, 2002) revealed that in a sample of 1,000 older persons, 4% claimed to be physically abused and in another smaller sample of 50 persons aged 70 years and over living in an urban area, 20% said they had been neglected in their households. There are estimates that elder abuse in India, in all communities and across all sections of the society, is on the rise. Increasing media coverage, stories

filed by journalists (Verma, 1996; Mitra, 1998; Paul, 1998), news paper clippings (Menon, 1998; Martyris, 1999; Mehta, 2000; Sharma, 2001; Sangwan, 2004; Shoma, 2004; Hindustan Times Metro, 2006; Gomes, 2006; Choks, 2008), T. V. coverage in serials, discussions and news, films, literary stories, some published autobiographical account, small scale qualitative studies (Mahajan, A., 1992; Vaithi, 1996; Bambawale, 1997; Prasad, 1997; Shankardass, 1997; 2002, 2004; Ushasree & Basha, 1999), and NGO activities (F.N.1) directed towards addressing the multitude of issues related to the abuse, all depict abuse of older persons in some form or the other.

There is also now increasing evidence from crime records and court proceedings which indicate that elder abuse is no longer a hushed affair. Older people who because of question of family shame and regard for their adult children were earlier suffering in silence are gradually coming out in the public with their 'horror and disgraceful' stories, their loss of dignity. For instance, Senior's Cell at police Headquarters in Delhi in June 2007 reported to be on a daily contact with 50 senior citizens through their helpline and analysis of distress calls made by older people in 2006 and half year of 2007 revealed 4% complains related to property and tenant dispute, 7% to harassment by other people other than family, 39% complained of family disputes, 7% sought police assistance, 12% complained of public nuisance in neighborhood, 2% had problems with civic agencies and the rest were termed as miscellaneous (Singh, 2007). An analysis of actual complaints received at the Cell indicated 43% older people having disputes with family members, 11% with neighbors, and other 11% were threatened or harassed by others, 4% complained about being cheated, while another 4% complained about disputes with tenants or landlord and 8% had property disputes with others. 8% had complained about problems with authorities and 8% complains were termed as miscellaneous, while 2% were against police assistance.

Evidence of growing incidence and prevalence is also being estimated by increases of old age homes and demand for institutional care and care providers / givers from outside the family. Institutional provisions in the form of old age homes are no longer viewed as unacceptable places as they were before and are now being seen as possible alternative and necessity by some older people and their families

(Flash, 2001; Chauhan, 2006). The emerging concept of senior citizens complexes or retirement retreats is a testimony to this growing phenomenon. However, this raises another dimension of elder abuse, so far overlooked, that is, of elder abuse in community and institutional settings and this has emerged as a growing concern in India.

Some though point out that even in the past there were instances of marginalization of older persons, of neglect and deprivation, but these were rare and generally associated with lower economic strata. In fact for some the practice of older persons retiring to ashrams was not always because of choice and it would be wrong to assume that it was only for religious considerations. As observed the idea of renouncing the world, isolating oneself from worldly goods, possessions, relations, etc., is probably due to lack of connectedness with the family, community and other agencies in the society (Shankardass, 2000).

Certain reports from different parts of the country characterize neglect/abuse as habitual scolding, nagging, non-communication, as well as feigned ignorance about their needs and ailments, material and sexual exploitation (Bambawale, 1997; Bose and Shankardass, 2004; Dandekar, 1996; Karlekar, Agarwal & Ganjoo, 1995; Karlekar, 2003; Mehta, 2000; Shankardass, 1997, 2002, 2003 [a], [b]). A report brought out by the women's organization *Karmika* argues that many forms of neglect/abuse could be sometimes worse than physical injury (MARG, 1996).

Some of these studies also indicate the experience of physical assault by older people. Media reports in the last few years, 2000 onwards in particular, point towards the existence of many forms of abuse of older persons, including physical, emotional, psychological, financial, spousal and sexual abuse. Newspaper reporting on an elderly person or a couple being murdered or thrown out of the house, deprived of their property and income are now almost a regular feature in national dailies. Material exploitation at the societal level and also in the family is the commonest type of abuse of the elderly which is reported by the media and also seen through crime record reports.

My research with older people has many narrations of elder abuse living in difficult situations and being constantly exposed to abusive environments. Some older people have stated on a few occasions to

being hit, or more specifically slapped, by their sons, daughters-in-law and even daughters. A few narrate things being thrown at them when they have not done as desired by their children. Instances of burning, scalding, being pushed around have also been narrated. A few narrate being pushed around and experiencing rough handling. Spitting on them is a common expression of showing disregard. The threat of being physically assaulted is faced by many older people in vulnerable situations. It is a step adopted by children for making the old parents do something against their wishes. There are narratives of older persons being excessively restrained through various means from doing things undesired by their children. Many older persons experience undue pressure to do things against their wishes. Controlling the older person from spending the money or participating in activities according to their own wishes is another form of abusive behavior experienced. In more subtle forms abuse is visible in the form of putting the health of the older person at risk and many older people do not realize this. Another form of abuse is when poor or limited care is provided for the older person. There are also narrations of older persons from different socio-economic groups experiencing on a regular or occasional basis humiliating behavior. They are forced to eat unappetizing/ unwanted food and often treated like a servant. Also in certain cases when old parents are hospitalized, there is failure to serve appetizing, nutritious food and provide adequate personal care. Some experience excessive physical restraints, for instance not letting them move out of the room, or in some cases medications are administered to subdue them so that they do not make any demands and remain tucked away in a corner.

Also a few NGOs, for instance, Development, Welfare and Research Foundation (DWARF, 2002, 2003), working with older people have documented stories, experiences of physical assault, material exploitation, verbal humiliation, excessive restraint, putting older persons' health at risk, poor or no care, putting undue pressure on the older persons, and exposing them to humiliating behavior, institutionalizing them on the face of it for their benefit but actually putting them in another kind of abusive environment. Studies of old age homes indicate that older people residing there are seldom visited by family members, and trained staff to take care are not available. Many old age homes are seen to be lacking in meeting the needs of older people, especially

in terms of long term and acute care (Dandekar, 1996; Shankardass, 2000).

While it is true that in India there is little well documented and statistically analyzed national level information on attitudes and behavior of young people in families and communities at large towards older people, a few studies on family inter and intra generational relationships, support networks and review of concerns emerging out of ageing of the population (Shankardass and Kumar, 1996; Bose and Shankardass, 2004; Karlekar, 1995, 2003; Puri, 2004; Shankardass, 1996, 1998, 1999) establish that a situation of dependency on the younger generation is a risk factor for neglect and in some cases, ill-treatment, and different forms of violence against older people in all kinds of settings, for instance, in families, communities, neighborhoods, and in institutions.

Government Recognition of the Issue of Elder Abuse

The National Policy on Older Persons formulated in January 1999 by the Ministry of Social Justice and Empowerment does not refer specifically to the incidence and prevalence of elder abuse but does acknowledge it as a concern which emerges due to "pressures and fissures in living arrangements of older persons" as a consequence of demographic ageing of the population in the country (GoI, 1999). The Policy, on the one hand under the section on implications of demographic trends, which are seen at the macro and the household level, stresses that family ties in India are strong with an overwhelming majority of older persons living with their sons or being supported by them and also that working couples find the presence of old parents emotionally bonding and of great help in managing the household and caring for children. It nonetheless, acknowledges that due to the operation of several forces, the position of a large number of older persons has become vulnerable. They can not take it for granted that their children will be able to look after them when they need care in old age, especially in view of the longer life span implying an extended period of dependency and higher costs to meet health and other needs (Para. 10).

Further the Policy document outlines - "Much higher costs of bringing up and educating children and pressures for gratification of their own desires affects the transfer of a share of income for the care of the parents." In understanding the changes in values and life styles

which impact the lives of older persons negatively, the Policy refers to shortage of space in dwellings in urban areas and high rents whereby migrants prefer to leave their parents in their native place. It further elaborates, "Changing roles and expectations of women, their concept of privacy and space, desire not to be encumbered by caring responsibilities of old people for long periods, career ambitions, and employment outside the home implies considerably reduced time for care giving. Also, adoption of small family norm by a growing number of people implies the availability of fewer care givers especially since in an increasing number of families, daughters, too, are fully occupied, pursuing their educational or work career". The concern in the Policy is more visible with regard to the older women as attention is brought to their greater vulnerability as single individuals since few people are willing to take care of non-linear relatives, especially widows who have no independent source of income, do not own assets and are totally dependent (Para 11).

Even after considering the strains and constrains in family relationships and its impact on the care of older persons, the policy document advocates for the care of older people by families and outlines certain modalities for supporting the care mechanisms in the community. The Policy Statement under the section on 'Principal areas of intervention and action strategies' refers to assisting voluntary organizations and associations of older persons in providing protective services and help to older persons through helpline services, legal aid and other measures. Further, it directs the police to keep a vigil on older couples and more specifically on old single persons, especially those living alone, and to strengthen the neighborhood watch system. It however does not outline the mechanisms by which there could be institutionalization of processes through which primary service systems relevant to the prevention, early detection and intervention of elder abuse or neglect or mistreatment, whatever may be the term, can be put in place to serve older adults and their families. It nonetheless takes recourse in suggesting a legal framework for tackling deprivation and exploitation of older people.

The Policy Statement under section 'Principal areas of intervention and action strategies' notes that "old persons have become soft targets for criminal elements." It gives a hope of combating the problem by

providing under the section on 'Protection of Life and Property' a promise for the introduction of a clause in the Indian Penal Code which shall protect older persons from domestic violence, specifically in the context of deprivation of their rights of inheritance, occupancy, etc.

In recent times, legislation on domestic violence has been put in place after recognizing that statistics of crime are irrefutably confirming that women, including those who are older, are victims of domestic violence. Certain social scientists have also documented older women as victims of domestic violence (Shankardass, 1997). While The Protection of Women from Domestic Violence Act, 2005 which was passed by the Lok Sabha on 24th August, 2005 and by Rajya Sabha on 29th August, 2005 and it received the assent of the President of India on 13th September 2005 to come on the Statute Book as ACT 43 of 2005, in spirit and intent is for the protection of women, it also recognizes violence towards older persons, which occur in the context of a breakdown in social relations between persons and their family. These are manifested through a continuum of multiple and often inter-related factors. It can vary from the most private, in spaces of domestic and matrimonial relationships, considered distinctly sacred (Jaising and Sakhrani, 2007). The Protection of Women from Domestic Violence Act enacted in 2005 is a law specifically meant to address the issue of domestic violence by providing for civil relief with a view to ensuring immediate and emergency relief to those facing violence in intimate relationships.

Significantly, the Planning Commission of India in the 11th Five Year Plan recognizes the marginalization of older persons and consequently recommends a specific Health Care Plan for the Elderly, which could reduce their neglect and abuse in society. It calls for the training of medical and nursing professionals, para-medicals and other categories of care givers in geriatrics in order to provide for the growing need for such services. It also suggests opening of geriatric clinics and hospitals in cities and at the district level. Lack of health care provisions makes older people vulnerable to neglect, mistreatment and abuse.

Clearly, in India as in many other countries there is age discrimination, the usual low pensions, marginalization of older people due to structural adjustment programs in social and economic policy,

and all these do result in violation of human rights and socioeconomic deprivations. A significant issue is - will the neglect, isolation and deprivation of older people resulting out of these factors be termed as 'abuse' and our societies as 'abusive environments'? If so, what models do we adopt to combat abuse and reduce abusive conditions, when the word 'abusive' as an adjective includes in its meaning improper use or action, tending to deceive, cheat, damage, weaken, be physically injurious and also involve illegality, besides employing harsh insulting language.

Addressing the Issue of Elder Abuse: Some Dilemmas

Understanding the prevalence of abuse is linked to identifying the different systems in which this social problem is addressed. For instance, if we define elder abuse within the parameters of social service system response then the growth of agencies on aging, such as not-for-profit community-based services to older adults and increased provisions for adult protective service programs mandated by state can provide us clue about its incidence and prevalence. Similarly if we regard abuse as a mental health issue, then growth and utilization of counseling centers, training programs, stress relief interventions can provide indications about abuse. Similarly if we view abuse as a legal issue, the response from the criminal justice system, the police, the courts, lawyers, judges, etc. become our guide to understand the incidence and prevalence of abuse, whichever way it is defined.

Each system, social services, health and criminal justice system, under which we define and give form to understanding abuse, generates its own remedies. The social services system tackles strained relationships but has limited powers to protect older victims who are mentally or physically impaired and are refused care. Health and mental care systems provide medical and psychiatric care to impaired older adults, but may not be prepared to diagnose stress-related health problems or undernourishment among older patients as related to psychological or financial abuse. The criminal justice system may generate legal remedies, but be unprepared for or unaware of the social consequence of these remedies (Shankardass, 2007). For example, a legal solution of older people separating from their adult children is probably not the answer to tackle their requirement for care.

In addition to differing categories of elder abuse, and different service systems serving older adults and their families that may come into contact with elder abuse and neglect, there are also two primary settings in which abuse or neglect can occur, each with its own legislative and reporting mandates, remedies and constraints. These are domestic or community settings and institutional settings. For instance, institutional abuse is tackled legally in terms of the liability of those who organize and run institutions/old age homes with an obligation to care for the residents. However, there is little awareness about the fact that institutions involved with caring for older persons do have legal liability and obligation to perform their task through the Indian Contract Act 1872 and the Law of "Torts" whereby for any mistreatment and failure in caring, a civil suit can be filed against the management of the institution for the breach in contract to care, even though there might not be a written contract and damages can be claimed for the wrong done (Bakshi, 2000; Shankardass, 2003 [b]). Institutions for meeting the needs of older persons have not so far been brought under legal purview in order to alleviate elder abuse but there is need to take seriously the provision in the Indian Penal Code under which breach of contract may attract criminal liability (DWARF, 2002).

Professionals working with elder abuse victims and their families are challenged to confront professional ethical mandates to respect the autonomy of their clients or patients. For instance, while providing service such as counseling it might not be within the mandate of the professional or the concerned organization to report the case of abuse to the police. The professional can only advise and suggest reporting to police as a remedial action but it is the prerogative of the victim to take action. The State is judicious in defining the circumstances in which and the extent to which it can intervene into the private lives of individuals and families. Two areas of intervention legislated to date are (1) when a serious crime has been committed against one family member by another, and (2) when victims lack the capacity to protect themselves from harm. Overriding the autonomy of unimpaired abuse victims because of their age alone is a matter of serious consideration for professionals and lawmakers. However, not to attempt to prevent or detect at an early stage suspected or known instances of elder abuse is also troubling, particularly for those in the helping professions.

Prevention Program Models

While there are difficulties in establishing a nationally uniform response system to elder abuse and neglect as a significant social problem of concern, some innovative elder abuse prevention programs and initiatives can be developed within social service, health and mental health, and criminal justice frames.

- Community-based services for older people including nutrition programs, transportation, case management, selected home care, information and referral, advocacy, and other services intended to empower older people to be self-directing for as long as possible can be useful.
- Public education campaigns that define elder abuse and neglect and explain how older adults can protect themselves from abuse and neglect have an important role to play.
- Developing Caregivers' support programs which are intended to educate and provide emotional support to caregivers of older people can help to prevent abuse and neglect.
- Establishing 'Respite Care' services to enable caregivers to get a break from the pressure of care giving, particularly if the older adult being cared for is an Alzheimer's patient, can help to prevent abuse and neglect.
- Encouraging counseling for family members who may have unresolved conflicts with older adult family members and are at risk of becoming abusive is a necessary tool to prevent abuse and neglect.
- In the health care field elder abuse prevention can be prompted by initiatives, such as, education of physicians and nurses on elder abuse and abuse prevention. It is important that the health care system develop and implement prevention strategies as well as detection and intervention strategies to address elder abuse and neglect among patients.
- Preventive criminal justice programs can include distribution of handbooks that include information on older peoples' rights as a means for elder abuse prevention.

- The courts can become active in fraud and abuse prevention by tackling cases in time, without delay.
- Community policing initiatives have been developed that target prevention of elder abuse that rises to the level of a crime and these need to be strengthened and have wider coverage.
- In some states, legislations have been passed to strengthen state-based elder abuse prevention efforts. These need to be encouraged in other states too.
- But more than legislations, community education programs can be effective in prevention of abuse and neglect.
- Finally, to extend the service needs of elder abuse victims beyond the traditional aging service networks.

Conclusion

If combating elder abuse is the goal, which is increasingly being recognized by societies, then the target of services must be extended beyond older people to include the larger networks and community. Education and outreach, and engaging community organizations are essential. Besides in developing preventive and combating strategies, mechanisms to regulate care and monitor it in the family, community and institutional settings is necessary. What programs and initiatives can be undertaken requires an understanding within which they can operate. What measures need to be adopted from the social service, health and criminal justice perspectives require outlining and debating upon. The lack of a common definition that transcends the cultural and institutional and boundaries of agencies, institutions, countries and state limits the ability of policymakers, advocates, gerontologists and researchers to understand current trends in elder abuse and neglect. As a result, it is difficult to project future trends, recommend preventive measures, and plan for the kinds of services needed to understand and reduce the prevalence of elder abuse and neglect.

Given the circumstances there is definitely a need for dialogue, consciousness and societal response to tackle the issue of understanding prevalence of elder abuse in India especially since we observe abusive situations in many different settings and circumstances.

Foot Notes

- 1) Many non-government, voluntary and charitable organizations working at national, regional and local levels, for instance, Age Care India; Centre for the Welfare of the Aged; Development, Welfare and Research Foundation; Dignity Dialogue; Harmony Foundation; HelpAge India; Heritage Trust; OutReach; Indian Gerontological Association etc. have been working for the cause of older persons and bringing about awareness of the issue.

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Elder Abuse : Outcome of Changing Family Dynamics

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ABSTRACT

This paper traces a pattern of increasing elderly abuse amidst changes in the Indian family structure and function. The transition in interaction pattern, interpersonal relations and communication pattern leads to a serious threat for healthy aging. The exemplary short case studies reported here indicate that elders are encountering both physical and psychological distancing in joint as well as nuclear families. Youths in general have started asserting strongly for individual self, and are in a great hurry to have every source of pleasure regardless of its legitimacy. Their behavior and unconcerned attitudes towards aged family members are becoming apparent. With increasing individualism family members seem to assert for individual freedom, prefer to live with individualized likings. This life style does not allow them to care for the personal, physical and emotional needs of elders. Many times they actively or passively abuse them. The paper explores the possible solutions of such a grave social problem.

Key words : Elder abuse, Psychological distance, Old age homes.

The traditional welfare institutions and higher socio-cultural values of Indian society provided respect and care for the elderly people. The aged in the families were generally taken care of by the family itself (Raju, 2002). But increasing industrialization, modernization and urbanization have had negative impact on the traditional institutions

and socio-cultural values of the families (Misra, 1979). These have resulted in breaking of the joint family system and migration of children in search of jobs leading to the deterioration of the higher socio-cultural values of Indian society, and rapid transition in the structure and functioning of the family.

The structure in the family refers to the type of family (i.e. joint, nuclear and extended) and functioning denotes the dynamics of interaction, interpersonal relations and communication between family members. Healthy interaction between family members leads to healthy relationships created and reinforced by positive communication. But due to structural changes in the family the relations and the communication patterns have inevitably changed. This transition in all the three components is a serious threat for healthy aging at the level of the family.

Increasing individualism in youths has resulted in asserting strongly for individual self, and they are in a great hurry to have every source of pleasure ignoring others' consideration totally. Such attitudes may lead to indignity, disgracefulness, embarrassment, dishonor, disheartening, disregard, indifference, injustice, lack of care, psychological torture and unlimited hostility towards elders (Khan, 2004). Presently, older people cannot take it for granted that their children will be able to look after them when they need care in their old age (Reddy, 2002).

In India about 90 per cent of the elderly stay with the family (Radkar and Kaulageker, 2006). However, there are no sufficient data to show the quality of their care. Those 10% who are living alone or in old age homes can tell us the reasons for not living with the family and suffering from psychological pains.

The social and cultural heritage of the family as an institution of care of elders has already entered the risk zone. The dynamics of relations in the family are undergoing unprecedented changes. The emotional bondage the source of keeping the family intact, united and fully functioning are changing not only in joint families but also in nuclear families.

Migration out of the family in search of a good source of living is debasing the dynamics of families. It leads to break down of the family system and creates emotional deprivation among family members,

particularly in elders who had a different outlook on the family system, having a strong bondage of emotional relations and care of each other. The satisfaction of emotional needs of the individual in the family requires closer interaction.

Elderly people are encountering both physical and psychological distancing in families. They feel isolated and side tracked (Bajpai, 1998). These changes at the family level and unhealthy approaches some times hurt them and encourage them to relocate themselves in old age homes. Some times their family members force them to shift to old age homes. But, elders usually prefer to derive a sense of meaning of connectedness to their homes, their neighbourhoods and their natural environment (Prakash, 2004). For this they are usually ready to make compromises, which tax their physical and mental well being. Depression and emotional shocks are common among them. They develop negative emotions towards themselves due to lack of employment, low income and failing health, the newly added worries and feeling of neglect, loss of importance in the family, feeling of inadequacy, loneliness and of being unwanted (Bose, 1990). This in turn makes them sensitive to the physical and psychological world. A glimpse of abuses and changes in the family dynamics can be had from the selected stories of elderly persons, being presented in the subsequent paragraphs.

Case I

Mr. Rajeev Ranjan (name changed) is 71 years old, a resident of Bhopal, married and staying with his wife in an old age home for the last 8 years. He was a professor and held a government job in a reputed college as head of the department. His wife was a primary school teacher. Other family members are a son and a daughter, both married and settled and staying with their respective families. Recalling his early days, Mr. Ranjan said that when his children were young, they all stayed in government accommodation allotted to him. He said that he was very happy and contented at that time. He provided the best of everything to his children to the best of his abilities. Being a good father and husband, he had full faith in his children and wife regarding all financial, personal and social matters. He followed the advice given by them, especially by his wife, as he had confidence in

their decisions. They all took a joint decision to build their beautiful house.

His children were bright so they achieved success very early in life. His daughter got married in a reputed family of Gwalior. His son also was married in a respected family known to them. Mr. Ranjan and his wife were very affectionate and considerate towards their daughter-in-law and her parents, who would often come and stay in their house.

Before marriage, his son was very close to his father and very considerate too. But after his marriage, unfortunately, his relation with his parents changed. Mr. Ranjan maintained a close relationship with his daughter and started consulting her on various family matters. Due to some reasons, his son resented this, so the atmosphere at home became tense. After his retirement, the relationship with his son worsened and his daughter in-law was to a large extent responsible for this. He realized that his wife, who was his better half, was now dancing to the tunes' of his son, because he was more materialistically sound and influential. Without realizing the implication he was persuaded to sign on papers related to property. His son sold the property and invested the returns in his own name. The daughter-in-law and her parents resented even his presence and started insulting him. The situation worsened when his son manipulated the property. He forced Mr. and Mrs. Ranjan to leave their home.

All this disturbed both of them. Their health suffered a lot in the following years due to emotional stress. They both decided to live in an old age home to get care from others. Their pension is their only support. They suffered abuse of psychological, physical and financial nature by their own family members. Having been victims of prolonged stress, they realized the need for spiritual health and relaxation technique. But, they are apprehensive about what will happen when one of them dies. There is no care-giver in sight. Their greatest need and desire is for love and respect from their family members.

Case II

Mrs. Radhika (changed name) is a 68 years old woman, widow, staying alone in an old age home for the last 12 years. Her husband was a high court judge. They lived a very happy and prosperous life

with their three sons, who were very obedient and sincere in their childhood. Their hard work and the blessings of their elders made them successful in their life. Her elder son is a doctor and married with a girl of the same profession. They have their own nursing home at Raipur. They both are busy in their business so they refused to take care of their parents.

Her second son is a director of a well-known NGO working for rural development. He is also married in a reputed family. He was obedient but could not stand against his wife's decision that they could not take care of their parents. So her younger son, who is a professor by profession and stays in Bhopal with his family, takes care of his parents. Everything was cool and they lived healthy life. But the sudden departure of her husband changed the entire scenario. Mrs. Radhika sensed that her status was reduced and her daughter-in-law was displeased with her presence. Although she actively participated in household chores like cooking, escorting her grandchildren to school in the morning and to park in the evening, shopping, etc. One day in the presence of her son, her daughter-in-law slapped her after a serious argument. Then her son himself locked her in a dark room and refused to serve meals to her.

After 3 days, in the absence of her son and daughter-in-law, one of their servants opened the door and advised her to leave the house. He also gave her some money. Then she left the house and joined an old age home. She has been staying there for the last 12 years. Her sons did not even try to search for their mother. Now she feels cheated and abused by her own family members. She gets the pension of her husband for livelihood.

Case III

Mr. Charanjeet Singh, a 70 years old man, is father of two worthy sons and a daughter. He lives on the ground floor of a two-storey building with his married elder son. His younger son occupies the upper portion of the building, which he himself built in his prime time. Mrs. Charanjeet Singh stays with the younger son.

Describing his problem, Mr. Charanjeet Singh said, "The relations between my two sons and their families are not cordial. They did not

allow me to talk to my wife, who lives with my younger son in the upper portion of my house. We get only two meals from our sons. They do not even entertain my guests. We don't have any say in the family affairs. I am living a very embarrassing life".

Case IV

Mrs. Roshini, a 68-year-old lady, who lived her entire life with dignity and prosperity, was forced by her family members to live in the outhouse of their house. This happened when she handed her entire property to her son-in-law. A maid was kept for her support. But after the death of the maid, she cooks her own food. The daughter and the son-in-law do not care her in any way and she feels lonely and rejected.

Case V

Mr. Hasan, aged 69, unmarried, eldest among six siblings. He lives in an old age home. He lost his parents very early in his life and all responsibilities fell on his shoulder. He somehow completed his graduation and got job in a bank. He poured all his earning in education of his three younger sisters and two brothers. After completion of their studies all of them settled and got married. Now all are busy with their respective families and there is no one to take care of him. He is very upset and curses himself for supporting the family members who rejected him.

These case studies give us a glimpse of elderly abuse prevalent in Indian society and its effect on the mental health of elderly persons. These case studies suggest that abuse of the elderly in the family is increasing from psychological torture to physical torture including insults, humiliation and partial or total denial of food, clothing, shelter and medical help and emotional support. It is more pronounced in the case of those who are dependent on their family members for every type of support, having nothing or very little to contribute to the family either physically or materially and are in constant need of care. In these examples poverty is not the major cause of abuse. Old people are abused in affluent families as well.

These case studies tend to suggest the 'motive for self' as overriding the family values and being the sole basis of untimely aging. Each member of the family wants to have their own choice of living.

The youth particularly, have started asserting strongly for the individual self, and they are in a great hurry to have every source of pleasure regardless of its legitimacy. Everybody in the family strives for individual freedom and prefers to live with individualized liking, thinking, eating and moving around. They hardly care for the personal, physical and emotional needs of the elderly members. Sometimes family members fail to meet the physical, social and/or emotional needs of the elderly persons.

The severity of elderly abuse is increasing day by day. The worst sufferers in the society are elderly people (Khan, 2004) but there is big gap between the problems of the aged and the available resources. Although voluntary organizations are engaged in taking care of the elderly, their limitations disable them from addressing the magnitude of the problem.

Under such circumstances, what should be the responsibility of the government ? Can older people claim it to be their right to be looked after fully in families for healthy aging? Can a society reconcile the emerging individualism of the youth with compassion and care for the elderly ? Can any government policy address a problem of such high magnitude and complexity? Can any formal institution replace the family care most needed by the Indian aged people?

No, no institution can replace the family. Therefore, the demand is to find a care model which supports elderly care while living in the family. This needs some community services to help the family in changing its mind-set and provide low cost care for the elders. WHO, India is involved in developing models for community based health care for the elderly for which projects have been conducted in Chennai, Jodhpur and Mizoram. Efforts have been made to utilize health workers engaged in other health-related or social service activities with additional nominal remuneration. Similarly ICMR has conducted a long project in rural south India and has offered a feasible model for the total health care of the rural aged within the existing infrastructure with some extra inputs. Other efforts are to be made in this direction to take care of the elderly in their families by providing community care. We offer some tentative suggestions which can be initiated to help the aged for positive aging, while living in the family.

1. Children, while going through the socialization process and education, should be made sensitive to the needs of their elders.
2. The government needs to start some training programs for elders, for the facilitation of positive and productive aging with the help of NGO's.
3. There must be some law against elderly abuse. Grown up sons and daughters must be forced by the law to take care of their aged parents and to meet their physical and psychological needs.
4. Realistic portrayal of old age and awareness and facilitation of positive and productive aging through various media channels is essential.
5. Joint activities, involving all age groups, related to community development, must be organized with the support of local government.
6. Essential training for assertiveness must be given to all elderly people.
7. Elders must be made to feel that they are desirable for the community.
8. Adequate training programme may be organized for caretakers, so that they can meet the demands of elders.
9. Visits of higher authorities to old age homes are strongly recommended as it helps in maintaining requisite standards of these places.
10. Grown up sons and daughters should be forced to visit old age homes on auspicious occasions, if it becomes necessary for them to relocate their parents there.

The aforesaid suggestions are not exhaustive and more can be added to the list. The strategies for the needed care of the aged have to depend on the basic assumption that in the Indian context the care has to be based in the families and old age homes cannot serve as an alternative of the family system. Old age homes, however may serve those who do not have families to look after them.

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Care -giving and Caregiver Stress: A Case Report

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ABSTRACT

In the Indian society, the cultural values and the traditional practices emphasize that the elderly members of the family should be treated with honor and respect. The families of the aged persons are expected to ensure the needed care and support for the aged. Elder abuse is seen often in cognitively impaired persons in addition to others with severe physical and psychiatric disabilities. It can take two forms- the patient being abused by the caregiver or caregiver himself being subjected to abuse. This paper intends to examine these issues of elder abuse in caregiver setting of patients with dementia in the light of available data of a long-term project by the authors and suggests its implications. In addition, the related issues of the problems, stresses, and strains of informal caregivers of the persons with dementia are highlighted.

Key words: Care-giving, Dementia, Emotional stress, Physical disabilities, Elder abuse.

The family constitutes the major caregiving response to the needs of the elderly who are no longer self-sufficient. These caregivers are often wives or daughters who have chosen to keep the patient at home with them. On an average, three-quarters of the caregiver's day is devoted to the patient, a proportion that tends to increase linearly as

the disease progresses. Caring for a person with disabilities can be physically demanding, especially for older caregivers, who make up half of all caregivers. Caring for a person with dementia at home can be overwhelming. The caregiver must cope with declining abilities and difficult behavior. Basic activities of daily living often become hard to manage for both the care-receiver and the caregiver. As the disease worsens, the care-receiver usually needs 24-hour care.

A large body of research now suggests that caring for an elderly family member with dementia can impose chronic stress that may harm the caregiver's emotional and physical health (Stone, 1994). Dementia has been studied as a risk factor for elder abuse. Conflicting data exist regarding this relationship. An observational cohort study of 68 elderly patients in New Haven, Connecticut demonstrated that older age, minority status, poor social networks, and functional (but not cognitive) disability based on Mental Status Questionnaire errors were risk factors for abuse (Lachs *et al.*, 1994). Many theories have been developed to explain abusive behavior toward elderly people. Theories of the origin of mistreatment of elders have been divided into four major categories, as follows: physical and mental impairment of the patient, caregiver stress, trans-generational violence, and psychopathology in the abuser. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psycho-social and cultural factors are involved.

Abuse may consist of single or repeated acts. It may be physical, verbal or psychological; it may be an act of neglect or an omission to act; or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. The most typical informal care giving involves the provision of assistance to elderly persons who, because of chronic illness and/or disability, need help with everyday activities. Abuse occurs in all social classes, and anyone is capable of becoming an abuser when he is under persistent and unrelenting stress.

Research has suggested that caregivers experience greater levels of emotional distress than the general population (Kiecolt-Glaser, 2001), such as higher levels of depression (Rosenthal 1993), with studies reporting the rate of depression in caregivers at twenty two per cent compared with eleven per cent for older people generally (Vitaliano 2003). A recent British study of dementia sufferers living in the community found that disturbed behaviour was relatively infrequent. Only ten per cent of the markedly demented, community-resident persons were described by their caregivers as noisy, five per cent as aggressive and six per cent as prone to wandering. When these problems arose, however, they were strongly associated with caregiver stress (O'Connor *et al.*, 1990).

It must be recognized that many caregivers in this situation are themselves elderly and at risk of abuse at the hands of the dementia sufferer. Some studies estimate that more than half of dementia sufferers manifest some form of aggressive behaviour—that is, verbal outbursts, physical threats or violence (Paveza *et al.*, 1992). In developing countries, where most of the world's older persons live - most of them are poor and there have not yet been many studies or systematic collection of statistics done on the stress of care giving and elder abuse. Even so, there is ample evidence from crime records, news reports filed by journalists, social welfare records and some small studies, that elder abuse - physical, emotional and financial is widespread.

There is paucity of literature dealing with elder developmental stage abuse. There is a debate over the treatment of elders in a child-like manner when they have regressed on the developmental scale, as with Alzheimer's disease. Most published researchers agree that an elder's lifestyle must be limited if their physical and mental abilities have deteriorated (Key *et al.*, 2000). However, there are limited developmental scale assessment instruments.

This paper examines the extent of elder abuse in a caregiver setting of patients with dementia in the light of available data of a long-term project by the authors and suggests its implications. Also discussed are the problems, stresses, and strains of caregivers of the persons with dementia.

Materials & Methods

Informal caregivers of persons with dementia fulfilling diagnostic criteria according to (ICD-10) were included. Four cases were selected from the fifteen cases seen where there was a mention of abuse by the care recipient as well as the caregiver.

The information was collected in the home environment during home visits by the first author with the questionnaires for both strain and other details. Caregiver Strain Index was used to quantify the strain. The Caregiver Strain Index (CSI) Zarit, *et al.* (1980) is a tool that can be used to quickly identify families with potential care giving concerns. It is a 13-question tool that measures strain related to care provision. There is at least one item for each of the following major domains: Employment, Financial, Physical, Social and Time. Positive responses to seven or more items on the index indicate a greater level of strain. This instrument can be used to assess individuals of any age who have assumed the role of caregiver for an older adult.

Socio-demographic data and other details were collected in a semi-structured interview and correlated with related variables.

Case 1

The caregiver, a 50-year-old daughter, with financial constraints has been made to look after her father aged 85 for the last 7 years. The caregiver complains of physical abuse by the patient like hitting on the head with whatever he lays his hands on whenever agitated. She also complains of his suspicious nature due to which he indulges in verbal abuse (using obscene words) in front of other family members, which embarrasses her, her relatives and neighbors. For this, she would argue with other family members, which is very disturbing and finds her self emotionally upset. She also vents out her financial problems as her husband works in a small hotel in Mumbai and has to look after four children, and that she cannot make both the ends meet.

She complains of being trapped by the family members who promised to support her and her family financially. She becomes touchy whenever spoken to and is easily moved to tears and expresses helplessness.

Caregiver variables

Caregiver: Daughter
Age: 50
Education: Primary
Occupation: Nil
Years of caregiving: 7 years
Patients relationship: Father
Strain experienced: 11/13

Patient variables

Patient: Mr. A
Age: 85
Education: Nil
Occupation: Farmer
Religion: Hindu
Marital status: Married
Family type: Nuclear

Women in the lower economic class, homemakers, faced a different problem of being victimized by an other family member, who is financially sound. They are being burdened to look after the older people who are difficult to handle. In the current case, the daughter was summoned to look after her ill father and was manipulated into taking up the responsibility forever. Her old father, who is a victim of dementia, subjected her to verbal and physical abuse. Financial support, which they promised, was denied and 'the maid-like' attitude towards her disturbed her mind.

Case 2

The 53-year-old wife is the informal caregiver of the patient. She narrates about how the patient is becoming a burden on the family members by his disturbing behavior like getting up at night, wandering, etc. She also narrates how their son can only control him by scolding and sometimes beating him. "He doesn't listen to any one in the house and we females cannot control him. Only my son can control him by scolding, and some times it requires some hitting to put him to sleep."

Caregiver variables

Caregiver: wife
Age: 53
Education: Primary
Occupation: House wife
Years of caregiving: 2 years
Patient's relationship: Husband
Strain experienced: 9/13

Patient variables

Patient: Mr. B
Age: 63
Education: Graduate
Occupation: Retired Bank Officer
Religion: Hindu
Family type: Extended

In this case his well-educated son who is a doctor abuses the patient who is a victim of Alzheimer's disease. Verbal and physical

abuse has become a part of caregiving whenever a patient shows non-cooperation.

Case 3

In this case, the narrator is a 34-years-old daughter- in-law who is looking after her 80-years-old mother-in-law. The caregiver says she is not much strained looking after her mother-in-law. The narrator showed her hostility towards other family members who did not share the responsibility of care giving. The patient has two sons and two daughters who at present are not staying with their mother except the elder son the narrator's husband. She be meant "Her other children are enjoying life without any responsibility. I am trapped here in this house looking after her and cannot leave her and go anywhere. I feel mentally tortured and some times show my frustration by abusing her verbally".

Caregiver variables

Caregiver: Daughter-in-law
Age: 34
Education: SSLC
Occupation: Housewife
Years of caregiving: 4 years
Patient's relationship: Mother-in-law
Strain experienced: 4/13

Patient variables

Patient: Mrs. C
Age: 80
Education: Nil
Occupation: Nil
Religion: Hindu
Marital status: Widow
Family type: Nuclear

Here the caregiver looked very frustrated by the burden of caregiving. The attitude towards her mother- in- law is a result of such frustration. Here the patient, depending on her family for care, is emotionally abused and humiliated, but remains powerless to stop it, due to her dependent situation.

Case 4

Mrs.C's caregiver is her youngest daughter. She is unmarried and lives with her mother taking care of her. In the process she is getting exposed to a high level of stress looking after a mother who has been suffering from dementia for the last three years and who is exhibiting disturbing behavior like wandering, depression and incontinence. The other family members, after their marriage, left her with their mother and live separately with their own families. She could not find any servant or social support as she resides in a rural area. She looks after

her mother without complaining as she thinks that it is her fate. She has a suicidal tendency as she says, "I feel like ending my life sometimes. My mother doesn't show any emotions and she is like a child herself. I live because of her and I am afraid of what lies ahead for us". She does not want to disclose any kind of abuse towards the patient during the interview.

Among caregivers of dementia, there is a gender-biased pattern of familial transmission of responsibility for care of relatives suffering from dementia and such responsibility becomes an important source of burden if the patient shows problematic behavior as is evidenced from this case vignette.

Caregiver variables

Caregiver: Daughter
Age: 26
Education: Graduate
Occupation: Business
Years of caregiving: 3 years
Patient's relationship: Mother
Strain experienced: 10/13

Patient variables

Patient Mrs. C
Age: 60
Education: Primary
Occupation: Nil
Religion: Hindu
Marital status: Widow
Family type: Nuclear

Result and discussion

The largest area of unidentified elder abuse and neglect is in the elderly population that remains in their own homes. Included in this area of abuse is also self-neglect (Tumosa, 1999). Unfortunately, signs that may be interpreted as abuse by a caregiver or family member may also be a sign of self-neglect by the elder. Failure of health care personnel to report suspected cases of elder abuse may cause loss of license and/or fines (Marshall, et al, 2000).

The four focus pairs selected varied from lower to higher strata of society and in the age range of 26 to 85 years. The participants, i.e., informal caregivers initially talked about "emotional problems", "lack of emotional support", "neglect by other family members", "feelings of insecurity", as reason for abuse in both the ways. However, not a single person was willing to label it as "abuse". They linked abuse to acts of violence, which they all seemed to agree was normal. In the current study defining abuse and its conceptualization was a problem.

In fact, there was a general uneasiness among the carers and a genuine attempt was made to evade the issue. On being forceful about the specific issues of physical abuse, verbal abuse and financial abuse, the carers agreed to the existence of such happenings in the community, at least within their own.

Taking advantage of the financial situation (case 1), family members are victimized by their own siblings or parents. This is a very uneasy situation for any outsider/researcher/social worker to intervene in and come up with the solutions even though the 'abused' implied for some kind of support or relief. Financial abuse was linked with people of the low-income group, especially women in the family who were dependent. The daughter was made to look after the sick father who abused her both physically and verbally, and her own close family relatives abused her.

One example at this point would be of Ms. D (case study 4) who never disclosed any kind of abuse of her mother. The avoidance of the issue is very evident which also points to the fact that whatever happened she was not willing to discuss.

Even physical abuse was sighted in one of the cases (case no 2). The symptoms such as restlessness, wandering and agitation exhibited by these patients led to verbal and the physical abuse by the caregiver which is an alarming trend of ignorance about the disease pattern which has to be taken up as a serious issue for discussion in all levels of society.

Another major factor was the fact that the older parents themselves were unaware of the abuse which they were facing and were inhibited to discuss this matter with the investigators to justify "neglect" in the existing circumstances. Whatever be the cause, carers were sympathetic towards their parents. The reason could be emotional bonding with the parents.

In case of Mrs C the daughter-in-law, who was frustrated in the family situation did not mention any evidence of abuse towards her mother-in-law other than verbal abuse, for which she was blaming other family members. This incident depicts the negative side of the Indian tradition where the daughters-in-law are still the weaker part of the family.

Woman in the present day Indian scenario has a traditional role entrusted to her as a caregiver in a largely patriarchal society, with no financial independence, and if she happens to be financially unsound (case 1 and 4), the world may not be a very nice place to live in.

There is substantial support for the idea that abuse is associated with personality problems of the caregiver, rather than characteristics of the elderly victim (Pillemer and Finkelhor 1989). The present study also indicated that females make up a greater proportion of caregivers than do adult males.

Informal supporters provide the bulk of long-term care to chronically disabled elders. Care giving has been recognized as an activity with perceived benefits and burdens. Caregivers may be prone to depression, grief, fatigue and changes in social relationships (Nelis *et al.*, 2007). They may also experience physical health problems and fatigue. Perceived caregiver burden has been associated with premature institutionalization and patient reports of unmet needs. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the care giving experience.

Mona Baumgarten *et al.* (1994) in their study of health of family members caring for elderly persons with dementia, suggest that the economic impact of dementia is a particular issue for families living in developing countries, and the combination of reduced family incomes and increased family expenditure on care is particularly stressful.

The reluctance to intervene in family affairs, difficulty in knowing how to cope with the problem when it is identified, and defining the problem are reasons given for why elder abuse has been ignored.

Conclusion

Dementia and elder abuse are relatively common and under-diagnosed geriatric syndromes. If risk factors for abuse are identified, the health care provider has the opportunity to intervene to prevent abuse. The success of primary prevention of elder abuse rests on the ability of the health care provider to make assessments and interventions and to maintain a consistent relationship with patients and caregivers. Education of the caregiver and attention to caregiver stress, including depression, may prevent the onset and perpetuation of abuse.

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Elder Abuse and Neglect : A Review

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ABSTRACT

Elder abuse /neglect/mistreatment is a widespread and serious problem. The term elder abuse and neglect is commonly used to describe acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult. There have been attempts to elucidate risk factors for elder mistreatment both for older adults and for their caretakers. These factors are based on etiologic theories for the occurrence of elder abuse and neglect. The present article touches on the concept of Elder abuse/neglect, the factors which contribute to elder abuse, the reasons why it is not reported by the victim, the characteristics of the abused and the abuser, manifestations of abuse and management issues.

Key words: Elder abuse and neglect, Physical abuse, Emotional abuse

Abuse of old people is an uncomfortable concept for health professionals. Elder abuse and neglect is a critical health care issue that must be brought to the attention of health care providers and older adults' family members. Adults older than 65 who live at home or in long-term care facilities may be at risk for abuse.

Although elder abuse and neglect has occurred for centuries, it is the most recent form of family violence to come to the attention of modern societies. Despite the efforts of health and social-care professionals to draw attention to the topic since the issue was first raised in the late 1970s, it is only since 1988 that the issues related to elder abuse and neglect have begun to be addressed. Elder abuse has

received increasing attention over the past decade as a common problem with serious consequences for the health and wellbeing of old people. Health and social-care professionals have not viewed work with older people very positively.

The proportion of older people in the world population is on the increase. The most striking effects of population aging are seen in the most rapidly developing regions such as China, India and Latin America. Due to the unprecedented pace of demographic aging, these societies will have comparatively little time to develop social and healthcare policies to deal with the healthcare needs of the elderly in their population (Randal & German 1999).

Elder abuse in family settings has increased in recent years for a variety of reasons, including the increasing proportion of older adults in the total population, the related increase in chronic disabling diseases, and the increasing involvement of families in care giving relationships with elders.

Elder abuse has been recorded since the 19th century, but it was not brought to the forefront until 1980. Each year approximately 10 per cent of adults, 65 years and older are abused, and 4 per cent experience moderate to severe abuse (Greenberg 1996; Weiler & Buckwalter 1992). Mistreatment of older people – referred to as “elder abuse” – was first described in British scientific journals in 1975 under the term “granny battering” (Baker, 1975; Burston 1975). Apart from the distress caused to the subject while alive, it is alarming to read in a recent article that elder mistreatment is associated with shorter survival, even after adjusting for other factors associated with increased mortality in older adults (Lachs *et al.*, 1998).

Elder abuse is an often overlooked and under-diagnosed malady (Collins 2006; Cohen *et al.*, 2006; Rodriguez *et al.*, 2006). Between 1 per cent and 10 per cent of elders are victims of abuse at some time (Cohen *et al.*, 2006). These individuals frequently present to the emergency department and often have multiple visits before abuse is uncovered (Lachs *et al.*, 1997).

Abuse varies in form and includes physical, sexual, and psychological maltreatment, financial exploitation, and neglect (Collins 2006; Cohen *et al.*, 2006; Rodriguez *et al.*, 2006; Wei & Herbers 2004).

Although elder abuse was first identified in developed countries, where most of the existing research has been conducted, anecdotal evidence and other reports from some developing countries have shown that it is a universal phenomenon. That elder abuse is being taken far more seriously now reflects the growing worldwide concern about human rights and gender equality, as well as about domestic violence and population ageing. In the West where "older age" begins is not precisely defined, which makes comparisons between studies and between countries difficult.

Concept of Elder Abuse

Elder abuse has been used as an all-inclusive term that is often used to represent physical abuse. Therefore, that already indicates that there are differences in the way elder abuse is interpreted. It may involve relationships between spouses, adult children, other relatives, maybe friends, and anyone else in whom the older person has placed trust. Other behavior that is considered abusive may depend on its duration, its frequency, its intensity, its intentionality, and the consequences.

Elder abuse thus encompasses the physical, sexual, or emotional abuse of an elderly person, usually one who is disabled or frail.

Elder abuse is an umbrella term used to describe one or more of the following:

Physical abuse is the willful infliction of physical pain or injury, such as slapping, bruising, sexually molesting, or restraining.

Sexual abuse is the infliction of non-consensual sexual contact of any kind.

Emotional or psychological abuse is the infliction of mental or emotional anguish, such as humiliating, intimidating, or threatening. *Psychological abuse* may include threats, insults, harassment, harsh orders, and behavior designed to increase social isolation. Stealing pension checks, not using funds for support of the elder, and/or inappropriate use of the elder's personal property constitute *financial and material abuse*. This latter form of abuse/neglect could also be alleged in the current case since the caretaker was using the decedent's funds, but not for her support. *Violations of rights* occur when the

caretaker deprives the individual of his or her inalienable rights, such as freedom of choice, life, or privacy.

Financial or material exploitation is the improper act or process of an individual, using the resources of an older person, without their consent, for someone else's benefit.

Neglect is the failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, such as abandonment, denial of food or health related services. *Neglect* is one of the more common forms of abuse and is characterized by a failure of the caregiver to provide the goods or services that are necessary for optimal functioning or to avoid harm. *Medical neglect* is the form of neglect where there is failure to seek medical care appropriate for the patient's condition.

Self-neglect is characterized as the behavior of an elderly person that threatens their own health or safety.

In 1987, the American Medical Association's Council on Scientific Affairs defined *elder abuse* as an act or omission that results in harm or threatened harm to the health or welfare of an elderly person. Elder abuse can be classified into 6 categories: (1) physical abuse, (2) sexual abuse, (3) neglect, (4) psychological abuse, (5) financial and material exploitation, and (6) violation of rights (AARP 1993).

Often, several types of abuse occur simultaneously. A family member who may initially take in an elderly patient may not be aware of the work and sacrifice involved and may become subject to the stress of the situation, which can lead to neglect or abuse. (Schor *et al.* 1995).

Elder abuse and neglect

While the term 'elder abuse and neglect' is commonly used to describe acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult, many authorities prefer to use the term 'elder mistreatment'. Mistreatment of the elderly person may include physical, psychological, or financial abuse or neglect, and it may be intentional or unintentional. Intentional mistreatment involves a conscious and deliberate attempt to inflict harm or injury, such as verbal abuse or battering; unintentional mistreatment occurs when an inadvertent action results in harm to the elderly person. Unintentional

mistreatment is usually due to ignorance, inexperience, or a lack of ability or desire of the caretaker to provide proper care.

Reasons for Not Reporting Elder Abuse

Elder abuse is a hidden, tragic secret for many. Sometimes victims simply do not have the capacity to report it. Whether a victim is unable or unwilling, some of the barriers to revealing elder abuse include

Fear :

- of being punished for reporting,
- of institutionalization,
- of rejection or abandonment by other family members,
- of losing their caregiver,
- of losing access to family members, including grandchildren that the disclosure will reflect poorly upon their family,
- Love for the abuser,
- The senior may care deeply for his/her abuser, leading to conflicting feelings about revealing the abuse. The victim is likely reluctant to see the abusers criticized or face consequences for the behavior.
- *Lack of understanding or impairment.* A victim may be unable to report the abuse because of cognitive impairment or other disability. A mental impairment or inappropriate medication may also keep a victim from revealing the abuse.
- *Shame and /or guilt.* Victims of elder abuse often blame themselves for violence and neglect they are subjected to. They are often reluctant to report the abuse because they are ashamed of what the family member did to them or embarrassed that they placed their trust in that person. The senior may also believe that it was something they did that brought on the abuse.
- *Unaware of resource options.* Victims are often unaware of the community supports and services available to assist them.
- *Acceptance of abuse or neglect as normal.* If abuse has been a prevalent or typical pattern of behavior in a family, both

the abusers and the victims may accept it as “normal” behavior. For many victims suffering at the hands of an abuser, violence and neglect are simply a way of life. Additionally, as violence is an accepted form of expressing rage in our society, the abuse may be dismissed and go unreported by others.

Besides, health professionals may ignore signs and symptoms of elder mistreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action, also their poor training in recognizing the condition, the subtle presentation of symptoms and signs, inherent unfavorable attitudes toward the elderly (ageism), reluctance to recognize that a problem exists, and fear of confronting or reporting the offender.

Characteristics of the Abused Victim and the Abuser

The abused elder most often has a cognitive impairment, lives in close proximity to the abuser, lives in social isolation, and is older than 75 years. (Lett 1995). An impaired patient - mentally or physically - is at greatest risk of mistreatment - particularly someone in need of assistance with feeding (Lachs *et al.*,1994) Characteristics of the abuser often include a history of mental illness and/or substance abuse, excessive dependence on the elder for financial support, and a history of violence or antisocial behavior outside the family (Lett 1995).

Caregivers experience “burnout” and frustration, which can lead to abuse of their ward. Alcohol abuse (by the patient or the caregiver) increases the risk of physical abuse and neglect. Finally, the personality and psychological character of the caregiver, as well as that of the patient, can play a causative role in situations involving mistreatment.

In a study to determine the family physicians’ perceptions of barriers and strategies in the effective detection and appropriate management of abused elderly people, physicians identified the barriers as denial of abuse, resistance to intervention, not knowing where to call for help, lack of protocols to assess and respond to abuse, lack of guidelines about confidentiality, fear of reprisal, and lack of knowledge of the prevalence and definition of elder abuse (Krueger *et al.*,1997).

Awareness of these factors can assist health care workers in identifying the individuals at risk.

The following factors should be considered when evaluating a potential case of elder mistreatment :

- Elder mistreatment occurs among men and women of all racial, ethnic and socioeconomic groups.
- The perpetrator of neglect is often the spouse or an adult child of the older person, but paid or informal caregivers may also be involved.
- Physical, functional, or cognitive problems in caregivers may prevent them from providing proper care
- Mental illness, alcoholism, or drug abuse in the older person or the caregiver may be associated with abuse and neglect.
- Social isolation and dependence of the elderly person may increase the risk for mistreatment.
- A past history of abusive relationships may predispose the victim to future mistreatment. Financial or other family problems may impair the ability to provide adequate care.
- Inadequate housing or unsafe conditions in the home may increase the likelihood of elder mistreatment.
- Victims often experience several forms of elder mistreatment at the same time.

Etiological Factors Related to Elder Abuse -Theories

There have been attempts to elucidate risk factors for elder mistreatment for both older adults and their caretakers. These factors are based on etiologic theories for the occurrence of elder abuse and neglect. Unfortunately, none of these theories has been substantiated with good clinical data. However, awareness of such factors, and the theories underlying them, may help physicians understand, anticipate and prevent situations in which elder mistreatment may occur.

The transgenerational or family violence theory asserts that violence is a learned behavior. Individuals who have witnessed or have been victims of family violence may deal with their problems in a like manner. A second theory implicates the psychopathology of the caretaker in some cases of elder mistreatment. Alcoholism, drug

addiction, or severe emotional problems on the part of the caretaker may predispose him to abusive behavior. A third theory argues that medical, functional, or cognitive disability of elderly persons increases their dependency and vulnerability, and therefore their risk for abuse or neglect. Other authorities point out that the caretaker may be dependent, especially economically, on the older patient. This dependency may lead to resentment and, when combined with other factors, may predispose to mistreatment. Other theories emphasize stress as an important factor in elder mistreatment. Although the care-giving role is inherently stressful, outside situations such as economic pressures, lack of community support, or increasing care needs may heighten tensions and produce frustrations that lead to abusive behavior. While one theory will not explain all or even a majority of cases of elder mistreatment, it is useful for clinicians to view the interaction of these factors as contributing to the overall behavior pattern.

Manifestations of Elder Abuse

Potential elder abuse can be detected through the elderly person's (1) fear of a family member or caregiver, (2) unexplained injuries, (3) very poor hygiene; and (4) appearance of elder neglect or mistreatment. Signs of physical restraint were also considered, but cases of financial abuse were not evident.

Elder abuse is mainly associated with a poor social network, and secondarily with some characteristics of the elderly senior. Abused elders are likely to have a poor social support system and numerous conflicts with family. They become isolated and often feel lonely. These seniors also have at least one of these characteristics: short-term memory loss, psychiatric illness, and problems with alcohol.

Abuse is like disease: if it is not considered in the differential diagnosis, it probably will not be diagnosed (Lett 1995). Recognition of elder abuse/neglect is difficult for several reasons, such as the lack of structured training in screening for abuse and the discomfort of discussing the topic with patients. Many of these elders will even deny help. Elders may deny abuse because they are ashamed of being abused or fear reprisal (Lett 1995).

There was no association between elder abuse or elder neglect and age, sex, marital status, or education. Studies have shown that

elderly people of all backgrounds may be vulnerable to abuse, which often goes undetected

Diagnosing Elder Abuse / Mistreatment

A careful history is imperative, although older adults may have difficulty in giving accurate information due of memory impairment. Sometimes they are reticent, being afraid of retaliation by the offender - either in the form of physical abuse or threats of abandonment. Sometimes the fear of being moved to a nursing home may repress reports of mistreatment.

Physical symptoms may be the dominant presenting complaints. The physician must ask directly about rough/harsh treatment, confinement or verbal abuse. Sometimes the information from the patient may be disguised or confused, or only given when the patient is away from the home, i.e., at the doctor's office or the nursing home. Usually, the patient should be interviewed alone in privacy. A good rapport is crucial in uncovering the information related to abuse. Questions should be directed towards the patient's view of daily life, covering such topics as meals, medication, and trips to the shops or park. There should be some questions about the relationship with the caregiver, e.g. "how do you and Ms X get along?" and "does Ms X take good care of you?" Likely signs of depression or alcohol abuse should be sought, and it may be appropriate to discuss finances.

If any issues of mistreatment are raised, the caregiver should be interviewed as well. Great care must be taken not to over-interpret the patient's complaints, especially if there is cognitive impairment. Information from several sources- relatives, friends and neighbors may be helpful and throw light on instances of abuse/mistreatment.

Medical assessment of the victim should include a complete history, complete physical examination, and documentation of all injuries. Multiple injuries at various stages of healing, unexplained injuries, delays between illness or injury onset and treatment, "doctor hopping," and multiple emergency department visits are a few of the findings. Pressure ulcers are often present in the elderly who are ill, and these should be thoroughly examined with all the dressings removed. Evidence of foul-smelling or necrotic pressure ulcers that have not been brought to the attention of the physician should raise suspicion of neglect (Schor 1995)

Results of the physical examination must be carefully and accurately recorded, as they may be needed as legal evidence of mistreatment. Signs of injury should be noted (traumatic alopecia, hematomas, burns, fractures or signs of previous fractures). Evidence of neglect may include unkempt appearance, weight loss, dehydration, poor oral hygiene, decubitus ulcers, inguinal rash, and fecal impaction. Any suspicious findings in the history or physical exam should be confirmed with laboratory and radiological exams, as this would be valuable. Thus, dehydration and malnutrition can be established with simple lab tests such as a complete blood count, blood urea nitrogen, creatinine, and total protein and albumin, and cholesterol levels. Results of all such tests should accompany the documentation of abuse/mistreatment.

Management

Abuse of the elderly occurs all over the world, and education is the key to detection. Elder abuse is often difficult to identify and occurs in all races and all socioeconomic groups. Knowledge of the risk factors can assist in preventing elder mistreatment, if the persons involved are prepared to address them. Screening patients and caregivers before placement, if feasible, can be helpful. Adequate frequency of physician visits and availability of social community support will help avoid the circumstances leading to mistreatment.

One of the most important developments in addressing elder abuse/mistreatment in recent years has been the use of multidisciplinary teams in hospitals and communities. Specialists in geriatrics, social work, nursing, psychiatry, and other fields offer insight that can help the primary care physician to develop an appropriate intervention plan. These specialists may have important referral information for patients or family members—support groups and other services in the community that focus on aging parents, home care, substance abuse, family violence, and financial and legal planning. Perhaps most important, physicians need to become familiar with long-term care and in-home health service options in their communities. Caring for an elderly parent at home is inherently stressful, and abusive situations can be prevented by providing support to overburdened caregivers.

Prevention of elder abuse : Strategies

At the most basic level, greater importance must be attached to primary prevention. This requires building a society in which older people are allowed to live out their lives in dignity, adequately provided with the necessities of life and with genuine opportunities for self-fulfillment. For those societies overwhelmed by poverty, the challenge is enormous. Prevention starts with awareness. One important way to raise awareness – both among the public and concerned professionals – is through education and training. Those providing health care and social services at all levels, both in the community and in institutional settings, should receive basic training on the detection of elder abuse. The media are a second powerful tool for raising awareness of the problem and its possible solutions, among the public as well as the authorities. Programmes, in which older people themselves play a leading role, for preventing abuse of the elderly in their homes include :

- recruiting and training older people to serve as visitors or companions to other older people who are isolated;
- creating support groups for victims of elder abuse;
- setting up community programmes to stimulate social interaction and participation among the elderly;
- building social networks of older people in villages, neighborhoods or housing units;
- working with older people to create “self-help” programmes that enable them to be productive.
- preventing elder abuse by helping abusers, particularly adult children, to resolve their own problems is a difficult task. Measures that may be useful include:
 - offering services for the treatment of mental health problems and substance abuse;
 - making jobs and education available;
 - finding new ways of resolving conflict, especially where the traditional role of older people in conflict resolution has been eroded.
 - much can also be done to prevent abuse of the elderly in institutional settings. Measures that may be useful include:

- the development and implementation of comprehensive care plans;
- training for staff;
- policies and programmes to address work related stress among staff;
- the development of policies and programmes to improve the physical and social environment of the institution.

Conclusion

The problem of elder abuse cannot be solved if the essential needs of older people – for food, shelter, security and access to health care – are not met. The nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where anti-ageing attitudes are discouraged, where older people are given the right to live in dignity – free of abuse and exploitation – and are given opportunities to participate fully in educational, cultural, spiritual and economic activities (Randal & German 1999).

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Narratives of Aged Widows on Abuse

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ABSTRACT

Based on in-depth interviews with the widows in the age group of 60 years and above, residing in various old age institutions in Kolkata and its adjoining areas, this paper examines the sufferings and humiliation (in terms of abuse and neglect) the women are subject to undergo by their dear and near ones, after the death of their husbands. The paper also seeks to analyze the implications for policy, programmes and practices related to abuse and neglect.

Key words : Gender differences, Status of older widows, Social taboos, Indian Culture.

The proportion of the elderly in the Indian population has been rising steadily over the last four decades, and the gender difference is sharply evident in the old age groups, with women outnumbering men. In India, out of the 73 million elderly people, 33 million are widows. Among 60+ population the proportion of widows in female population is 60 per cent while only 19.4 percent of the men are widowers in this age group. This was even more sharply defined among those who were above 70 years. About 77.6 percent of the women are widows compared to 21.7 per cent of their male counterparts (Chakravarty, 2001). Widows are considered to be a marginalized group in India because they occupy a very low social status in society. They are viewed as inauspicious and taboo in several social situations and rituals. Older widows are doubly affected due to the combined effects of aging and widowhood (Jamuna, 1989).

Conceptualizing the Widowhood: Widowhood as Social Death

Widowhood in India is a state of "social death" (Chakravarti, U, 2000). The widow's social death stems from her alienation from reproduction and sexuality following the loss of her husband and her exclusion from the functioning social unit of the family. Once a woman ceases to be wife (especially if she is childless) she ceases to be a 'person', daughter or a daughter-in-law. The problem posed by patriarchy therefore is this: since the wife has no social existence outside of her husband and his family, who, or what, is she as a widow? The problem itself simply stated is that although the widow is socially dead she remains as an element in society. The question is how to retain her in the main stream of society as an integral element. Another could be to retain her in society but place her on its margin and then institutionalize her marginality. This is what patriarchy did with the widow. The widow's institutionalized marginality, a liminal state between being physically alive but socially dead was the ultimate cultural outcome of the deprivation of the widow of her sexuality as well as her personhood.

The widow's marginal state means that she is, in a manner of speaking, functionally incorporated into the household while being considered an outsider. Thus while she is functionally incorporated either into the natal or affinal family, the widow is, especially in her affinal household a 'domestic enemy. At the same time she is the 'insider' who has fallen, one who has ceased to belong and been expelled from normal participation in the community (for failing to prevent the death of her husband). This is how widow-hood is conceived.

The death of a woman's husband marked the transition from wife to widow taking the woman from a central place in the family to its margin; thenceforth she was regarded as someone who was physically alive but socially dead. Deasi's (1997) case studies of institutionalized elderly women showed that the elderly women's status changed not just due to chronological ageing but when they lost their husbands. Until their husbands were alive they had a place to live. Even for women who earned more than their husbands, a house was not an inalienable resource, to call her own in old age. Thus widowhood leads to social, emotional and financial insecurity. A woman is recognized as a person, an auspicious social entity only when she is with her husband. Together with her husband she performs rituals and procreates a son or many

sons (Kane, 1941). These two acts define her as a social being and, for both the presence of the husband (who makes her complete) is imperative. Without the husband, the wife has no recognized existence in Hindu patriarchy. Thus, the state of widowhood is a great calamity in a patriarchal and traditional society like the Indian society and patriarchy has played the biggest role in the total marginalization of widows.

The Gender Lens - Widow Abuse

Feminist analysis starts with the gender. The gender represents a social construction (Berger and Luckman, 1966). That is, it relates to the roles, tasks, positions and assumptions associated with male and female within a particular social context. These roles and assumptions are internalized by those brought up within that society. Acting according to the ways a society prescribes or inhibits resistance to oppression and recreates the social construction of gender.

Power is, of course, central to the issue of the gender. The marginalization of older people and, in particular, older women (widows) in society is to be taken into account. The patriarchal context sees men as having access to greater power over the more vulnerable and less powerful and being protected by societal norms. The social construction of ageing as negative and stigmatizing is important (Bytheway, 1994).

Older women (widows) are marginalized in society on account of gender and age. The negative connotations of ageism and ideas of dependency and impairment aggregate in the negotiations of power within society. Ageism, sexism and structural divisions combine to create power imbalances that are predicated on the notion of women as being of inferior status. This facilitates the conditions in which abuse flourishes and militates against an easy or quick resolution. The socialisation of individuals in families is created by the wider social structures and cultural factors and, in turn, recreates them by subscribing to the gender and power games advanced. All these interact to produce individual experiences and behaviours some of which are fundamentally abusive and proscribed by society, some which are neither condoned nor proscribed, and some which are perpetuated within the existing social fabric. This is often internalized by individuals who then add to the maintenance and development of a gendered and unequal society.

Methodology

In the present study a broad definition of abuse was used, adapted from Article 1 of the United Nations Declaration on the Elimination of Violence Against Women. "Any acts of gender-based violence or threats of such acts, coercion or arbitrary deprivation of liberty, that results in, or is likely to result in harm or suffering to older women, including: physical abuse, psychological abuse, financial abuse, neglect, sexual assault, and violation of human rights" (United Nations 1993). Obviously, there is nothing in this statement which implies that women of any age are excluded from this definition.

The operational definition of 'aged widow' for this study included all widows 60 years old or older. Age 60 was chosen, recognizing the particular difficulties like social, economic, and emotional faced by widows who, because of advanced age and ageist attitude find great difficulty in adjustment in family.

The position of a widow in society is a crucial topic which sociologists, social workers; social researchers have to discuss and elucidate. The treatment women receive is often an index to the attitudes of society towards widows as a class. The sufferings of the widows are their own. Some other factors that affect the mental and physical health of the widows are loneliness, neglect, economic instability and illness. There is no uniform pattern of widowhood either in terms of conditions leading to such a phenomenon or in terms of any pattern of consequences. There is also no uniform lifestyle for widows. Life styles vary not only according to the location in the social system, be it in upper class area or a middle class area, or the slum, urban or rural areas, but also by the women's own combination of characteristics. Widowhood necessitates establishment of new relations within the family, with the kin-group and with the community. If such new relationships appear difficult to emerge, widows often have to take refuge into old age homes (Ranjan, 2001). In the light of the context of widowhood in India, a study to explore the links between widowhood and abuse was undertaken.

The specific objectives of this study were :

1. to find out the socio-economic condition of the aged widow;
2. to find out the role and status of the aged widow and her interpersonal relations in the family;

3. to study the nature and extent of abuse;
4. to identify the major social and psychological variables associated with being abuser or abused;
5. to find out socio-psychological problems faced by the abused widow;
6. to analyse the coping mechanisms available to the widows to improve their situation in the family.

Design of the Study

In order to understand the phenomenon of abuse towards the widows a qualitative research approach was found to be suitable. A qualitative approach provides a flexible framework and that is why a qualitative method was more appropriate in understanding the meaning of the problem of abuse experienced by the widows from their close kith and kin. The study was undertaken within the interpretative framework, conducted from a case study perspective, meaning that research was conducted to illuminate issues from the standpoint of the widows themselves and to capture complex, real life events and processes and following Yin's (1989) perspective on case studies to answer "how" questions, rather than "why" questions.

Sample

The researcher identified and selected the cases of abuse towards widows from and among the different Old Age Homes in and around Kolkata (W.B.). In West Bengal there are 733 widows in every thousand elderly females (Chakravarty, 2001). Over 42 percent women in Kolkata are widows and most of them (65 percent) have no support. (The Hindustan Times, Sept.1, 2004). In one of the surveyes, conducted by the Indian Society for Welfare of Senior Citizens, it was found that a large percentage of these destitute widows (45 percent) have children, but have been driven out of their home (The Hindustan Times, Sept 1, 2004). The justification behind selecting the cases from Old Age Homes supports the fact that abuse of widows is a serious "social malaise", though it remains largely hidden within the four walls of a house and is seldom reported. As a result, incidents like these are never highlighted and discussed because Indian culture and ethos do not sanction such behavior to happen in a family. Hence, keeping in mind this limitation, the researcher did not select the cases from the family set-up and

realized that once the widows are outside the family, they would feel more relaxed to articulate their life's experiences and feelings more candidly without any kind of 'fear'. Thus, the cases were identified through purposive sampling technique and subsequently selected by applying the snowball method.

The Researcher selected the cases on the basis of the criteria used by Goetz & LeCompte (1984), viz;

- Degree of mutual respect;
- Love, affection and attention;
- Physical closeness;
- Consulted when decisions are taken in the family;
- Time spent by family members with them;
- Allowed to move freely in the family;
- Have command over their day to day activities;
- Consulted on the major decisions of the family;
- Any change noticed in the interaction pattern with the son before and after his marriage;
- Children cooperate in feeling the life;
- Treatment before and after the husband's demise.

Data Collection

In the present study data was collected from 'primary' as well as 'secondary' sources. The primary sources constituted of the widows 60 years and above and were victims of abuse and neglect. Secondary sources include census reports, articles, newspaper reports, journals and books.

As the study was qualitative in nature, an *in-depth interview* (unstructured in form) was the primary tool for data collection,

The interviews were conducted according to 'Interview Topic Guide' which consisted of six broad items like:

1. Socio-economic condition,
2. Role and status and inter-personal relations,
3. Nature and extent of abuse,
4. Social and psychological variables,
5. Socio-psychological problems,
6. Coping mechanisms.

All the six broad items were divided into sub items and were open-ended in nature without any alternatives in order to facilitate in providing richer data.

The Contents of Data Analysis

The data obtained during the interviews were in the form of 'linguistic narration' or were of a qualitative in nature. The content of each interview was carefully analysed on the basis of the responses given by each respondent. The writes of analysis were how individuals recounted their histories - what they emphasize and omitted, their stance as protagonists or victims, the relationship the story established between the teller and the audience – all shape what an individual can claim of their own lives. Personal stories are not merely a way of telling someone (or oneself) about one's life; they are the means by which identities may be fashioned.

Presentation of Cases

Case Study -I

Mrs. Sangeeta Baidya is a 70 years old Hindu widow, formerly a resident of Kumilla District of Bangladesh, and came to West Bengal after the Partition of India. She had a small and a happy family of four members consisting of her husband, who was an *Ayurvedic* doctor, two children (a daughter and a son) and herself. She had no formal education but can read and write *Bengali* and a little bit of *English*. She is an avid lover of reading. Bengali novels. Basically she is a home-maker. The widow belongs to a lower middle class family and both her parents were from Bangladesh. She is the only daughter of her parents and her father owns some agricultural land of around two *bighas*, which sustains the family. At a young age of 19 years her parents got her married to a young 27 years old *Ayurvedic* doctor. After a year of marriage the first child, a daughter was born to them. The family had been carrying on well. Suddenly, because of political unrest in Bangladesh they were forced to migrate to West Bengal and settled in a place called Barrackpore in 24 Parganas (North). Her husband purchased some land where he built a two-room house and started living there. They admitted their daughter to a Bengali medium girls school nearby from where she completed her secondary level in the first division. "She was very good at studies. Always spent time

with books”, the mother remarked. Mrs. S and her husband wanted their daughter to become a doctor but the daughter cherished the dream of becoming a teacher. Meanwhile, she again becomes pregnant and this time a son was born to them. Both she and her husband were delighted and thought that in old age he would be a succor to them. In the month of February, the year she could not recollect, while practicing in his chamber, her husband started feeling pain in his chest. In the beginning the pain was very mild but towards noon it became unbearable. Mrs.S was immediately informed. She became very panicky and with the help of her neighbours she took her husband to a local nursing home. Hearing the news of his brother-in-law's illness her brother rushed to the nursing home. The doctors attended on him as an emergency case. Her two small children were dumb struck and shocked. The widow revealed that she had also got the feeling that her husband might not live anymore and therefore whenever she used to visit her husband she became very nervous. In spite of that, the widow recalled that she could take courage and served her husband in the best possible manner. She also prayed to God for his speedy recovery but unfortunately on the 8th day of her husband's illness, suddenly his condition deteriorated and he started having intense pain in the chest. She was beside him at that time along with her two children. She recalled that on seeing her husband screaming with pain she at once called the doctor. The doctors came and started checking him up. But soon after that he became unconscious and never regained consciousness. At that time she was just 40 years old. The widow said that she felt very sorry for not being able to talk to her husband at the last moment. When she reached home she fainted. “My husband was a great support to me, I didn't know what would happen to me”, said the widow. Her only brother who stays in Kolkata and is an employee of the Central government, consoled her and gave her moral as well as financial help. The expenses of the funeral ceremony and for the first 13 days of mourning were borne by him. She shouldered the responsibility of bringing up her children without any kind of financial help or moral support from her husband's family, although her husband's relatives stayed nearby. She educated all of them up to the graduation level and now they hold salaried jobs in the organized sector. She has not received any share from her in-laws property. She did not get any share from the property of her parents as well. The widow did not want to discuss

this issue with any person because she was not interested in such a matter. She managed her family from the monthly income scheme (MIS) in the post office, into which her husband had invested for her sake, which was around Rs.2,500/- per month. She was pulling on well and managing the affairs of her family. She never made her children feel the absence of their father. In fact, she thought that shaping her children's life would make her happy and secure in old age. Her daughter successfully passed her M.A. in Geography and obtained a good salaried job as a school teacher in an English medium school in Kolkata. She spent the major part of her salary in the maintenance of the family and on the education of her brother. After completion of her son's education the widow got her daughter married to a well-established engineer and both went to settle in New York. During this period, her son got a job in a State Bank in Kolkata. Both mother and son were living happily. And, one day his son came to his mother with a girl who worked in the same office with him and told her that they wanted to marry. The widow felt relieved thinking that since her daughter was far away from her, there was no body with whom she could talk and share her feelings, as his son came late in the evening. Eventually her son got married and the widow handed over the household responsibility with full confidence to her daughter-in-law. But the confidence was broken within six months of marriage. Petty quarrels started on issues like the widow's habit of rising early in the morning, bathing and sitting for the “*pooja*” which her daughter in law did not like at all as it disturbed their sleep. She is a strict vegetarian. Her cooking utensils were separate and she did her cooking in a separate area. But her daughter –in- law told her there couldn't be two sets of utensils in the same house and no separate arrangement for her cooking could be made. She had to adjust with them. This hurt her tremendously. She called her son and told the whole incident but he told her to do what his wife was telling her to do. There was agony and frustration on her face during the conversation while narrating these incidents. She is a patient of asthma and during the winter her breathing trouble gets worse. During one such winter she had a severe attack of asthma and she fell seriously ill. Her son took her to a doctor, bought the medicines for her, but her daughter–in-law was very indifferent to what was happening in the house. The doctor's fee and the cost of medicines were borne by the widow herself. Her son did not spend on his mother's treatment. Even during her period of

illness she cooked her own meal. Her daughter-in-law never bothered to look after her. She recalled, one day when she was reading "*The Gita*" in her room she heard a conversation between her son and daughter-in-law. Her daughter-in-law was pestering her husband to send her away to an old age home. Hearing such comment she felt very depressed and sad. Her husband had willed his property and savings to her. She managed her own financial affairs. One fine morning her son came to her and began pressing her to transfer the property to his name and go to an old age home, as the family members were increasing and there was paucity of space. Meanwhile the widow became a grandmother and relatives from the daughter-in-law's side started coming and staying with them. She refused to comply with her son's proposal which led to conflict and tension all around. "He is a violent man and hit me with a leather belt when I turned down his demand". As the situation worsened, feelings of insecurity, suspiciousness, and fear intensified, especially in the absence of a sympathetic ear to share her troubles. Above all, all her money was in a joint account with her son who refused to part with the passbook and bank statements. The old lady felt helpless. She approached her brother who stayed in the Shyam Bazaar area in Kolkata and described the whole incident and sought his advice. He tried to resolve the matters in vain. Her son was adamant. Finding no other way her brother suggested making a complaint to the police. She sued her son. He was suspended from his job also. The case continued for two years and ultimately the mother won and now she is regularly receiving alimony on a monthly basis as stipulated by the court. This case is very uncommon in its nature because parents seldom sue their children for maintenance. Her daughter who stays in New York came to know of the incident through a newspaper report. Immediately she flew from New York and came to her mother. She was ready to take her to America, but her mother did not agree to go. She told her daughter, A mother should not stay in a married daughter's house. If she had not have been married, her mother could have stayed with her. This case illustrates that widows are considered a 'liability' by their children. If the widows are owners of property the chances of being victims of abuse are more, as the perpetrators always try to usurp it. But widows can fight with courage and confidence if they get support and help from somewhere.

Case Study-II

Mrs. Anju Seal is an old Hindu widow who has been staying in an Old Age Home for four years. She hails from Dandakaranya in Bihar, but has been living in Kolkata for the past 30 years after her marriage. She is literate and was a homemaker. The widow comes from a middle income Hindu family. She was the eldest daughter of her parents. She could not study further because her parents married her off at the age of 14. "During those days early marriage was prevalent in the society", remarked the widow. Her husband was a Central Government employee in Bihar. He had a shifting duty; sometimes he had to work in the night shift also. Life was moving smoothly. During this period she gave birth to two children - a son and a daughter. Her son passed his secondary and higher secondary examination from Bihar Board. She became a widow at the age of 44 when her two children were 18 and 12 years old respectively. Her husband died during his service period as result of which the Government gave her a job which she passed on to her son thinking that it would be difficult for him to get a job on his own merit and qualification as he had Hindi medium.

After the death of her husband the family came to Kolkata and started staying in a rented house. She was surviving on her husband's pension, which amounted to Rs. 2000/- per month and her son also earning and providing financial support to the family. All her in-laws stayed in Kolkata but after the death of her husband no body from her in-laws' family approached the distressed family with any kind of support. When her elder brother came to know about her crisis he took her with him and arranged a rented accommodation for her near his house. He took the entire responsibility of looking after her daughter's education. Her daughter completed graduation and took up a job in the private sector. Economically the family was now in a more stable condition. Her sister-in-laws' husband now gave her information about piece of land which was around 5.5 katha and was on sale. She purchased the land with the financial help of her elder brother.

After working for a few years her son told her that he wanted to get married. She said he couldn't get married before his sister. He started shouting and abusing her. Tired and helpless she gave him her consent to marry the girl of his own choice.

From some source she came to know that her son had married this girl in the hope that in the future he might acquire a handsome property. The widow and her daughter started staying in the same house without any kind of communication with her son and daughter-in-law. After a few months of marriage the son started pressurizing the mother for money. He took more than he had contributed to the family by putting pressure on the mother. The widow anticipated that after the birth of her grandchildren the requirement for money would increase and simultaneously more emotional torture would be caused to her. Hence, she stopped taking money from him and they separated the kitchen. After a few years her daughter got married with an executive agriculture engineer. In the meanwhile the landlord raised the rent of the house and she was not financially sound enough to pay it. So, she moved to stay with her daughter, and her son too started living separately in a single rented room. Both of them were staying separately at different places in the city.

One day the son came to the mother and told her to transfer the 5.5 *katha* plot of land in his name as he was planning to build a house and would keep her with him in his new house. If the money was not arranged he would not get a house-loan from his office. At the same time he also threatened her that if she did not transfer the land in his name the mother-son relationship would not exist any more. She complied with his demand. Once the land was transferred in his name he told her that it would take some more time to get the house-loan from the office and demanded some more money from the maternal uncle. Thus, the demand for money increased. Being a mother she could not turn down the son's demand. She managed to get the money and also gave away all her savings; in the hope that he would keep her with him. The construction of the house was completed and she moved to her son's newly constructed house and started living with him. As there was only one room, she had to live in 'verandah'. But her kitchen was separate. She cooked her own food. Her daughter-in-law was least interested in her. Her neglect continued silently. She could not protest fearing that if she did so she would be out of the house. When her grandson started to grow-up their behavior became worse. Her staying was no more required and ultimately the situation became so complicated that she was compelled to leave the house and started

living in a rented house arranged by her daughter. Nobody spoke with her. Even if her grandson spent time with her, her daughter-in-law abused her saying that she was spoiling her son. One day her daughter-in-law even beat her. The widow felt the absence of her husband and was very lonely. After she left the house her son took loans from the bank for a further extension of the house.

Her daughter arranged an old age home for her for the rest of her life. Her son never visited there on the pretext that traveling in a bus caused suffocation. One day her daughter-in-law phoned her seeking some more money in order to build another floor and saying she would give the ground floor on rent and allot the first floor to her. This time she strongly rejected the proposal and told her daughter-in-law that she was quite happy in the old age home. She feels very dejected about the young generation's selfish attitude towards the old people.

The above narration shows that materialistic and individualistic attitudes are the top priorities for the younger people of today's generation. The philosophy of "WE" has been replaced by "I", Values like sacrifice are fast declining.

Case Study-III

Mrs. Moly Dey, a 77 years old Hindu widow, has been an inmate of old age home for six years. She was the youngest child of her parents. Her father was a school teacher. As he was poor, he kept her with her uncle who brought her up. She was been educated up to the 7th standard. She was married at the age of 18. She used to stay in Dhaka. After marriage she came with her husband to West Bengal. Her husband was a Diploma engineer and was employed as a schoolteacher for two years, and later joined a private company. She had a son and a daughter. After her marriage, she started staying with her husband's elder brother in Kolkata whose wife died when his son was 5 years old. Mrs. M. brought him up and never made him feel the absence of his mother. She led a happy life till she lost her husband at the age of 54 years. After a few years of her husband's death, she married her daughter to an engineer who worked in a reputed multinational company. After their marriage they went to settle in Mumbai. Her son had a business and took great care of her.

The widow recalls the rainy days in a pathetic manner. "It was during rainy days that God mercilessly snatched away my son. I have lost all my happiness since then." The widow said that her son was returning home on his motorcycle at 7 in the evening when his motorcycle skidded on a slippery road and he received a head injury and become unconscious. When his condition started deteriorating, her husband's elder brother's son (her nephew) started with drawing from the situation and avoided her, recalled she.

After suffering painfully for two days her son breathed his last. All the expense of the funeral were borne by her daughter and her son-in-law as she was financially exhausted during the treatment. Since the widow was staying with her nephew in a rented house, after his marriage they moved to a new house built by her nephew. It consisted of two rooms, one kitchen and a bathroom. The widow suggested, him to build another room for her stay, but her nephew's wife rejected her proposal.

During this period her nephew lost his job as the company where he worked was closed down. The family was passing through a very disturbing phase. He tried hard to get a job but when he failed he started coaching school children in the morning and in the evening his wife ran a dance class. The coaching classes and the dance classes were held in the same room where Moly was staying. She could not sleep till the classes were over. She had no access to the other room. So silently she had to bear the torture. She was not allowed to do any household work. Her nephew's wife made cutting remarks, shouted at her husband and often used foul language.

One day her nephew approached her and told her that he had found a place where she could live peacefully. The place was an old age home. Initially, she was a little bit reluctant to go, but ultimately thought that old age home would be far better than where she was staying. She agreed to the suggestion and moved to the old age home. The expenses were borne by the nephew. He paid visits to her and during Durga Pooja he comes to give new clothes.

Asked about her expectation, she said, "women should be economically independent and should take their own decisions in life. At the same time she said that if she could be a working woman such

situation might not arise. The Government must come up with some programmes for poor widows like me."

The inference from this case is that the kind of treatment and respect of a widow in a family depends on the attitude of the people with whom she is staying and the amount of property she possesses. If she had been owner of some property, her kith and kin would perhaps have taken care of her. On the other hand, if she had been educated it would have been easy to take her own decision about her life.

Case Study-IV

Mrs. Mukti Dev, a 62 years old Hindu widow has been an inmate of an old age home since 2001. She belongs to rural area of West Bengal. She studied up to primary level. She knows cutting and tailoring but had never used her skills to earn her livelihood. The reason was that she has a eyesight problem from childhood as a result of which the doctor had advised her not to do any activities which could strain the eyes. She has an elder brother and an elder sister. Her elder sister was married and is in North Bengal but her elder brother remained unmarried. He owns a petty grocery shop. She got married at the age of 27 years. Her husband was a graduate and was employed as a Superintendent in Kolkata Telephone Department. They had no children. As she had some gynecological problem, she could not conceive.

She was living in a joint family, where she had a father-in-law and a sister-in-law, who is a spinster and is employed in a private school as a teacher. The whole family used to stay in a rented house in South Kolkata. "My father-in-law used to work in a private company. Whatever savings he had were spent in the treatment of my mother-in-law who had cancer. My husband lost his mother when he was 32. From that time, my husband shouldered the responsibility of the family taking care of his father and sister", recalled the widow. She came into the family after the death of her mother in law. After marriage when she came to her in-laws' house, from the very first day of her entry she observed that her sister-in-law behaved towards her in a very 'strange' manner. She reasoned that it was because she belonged to a poor family and could not bring enough dowry with her. Also she was from rural background. For no reason the sister-in-law would find fault in her work, though she tried to do her best. "As I was a simple rural

woman, sometimes I failed to understand the 'knitty gritty' of the urban mode of life." The complexity of the urban life is hard to understand. She was dominating in nature and got a lot of importance in the family from her husband and father-in-law. If any major or minor decisions were to be taken my husband and my father-in-law always consulted her. They never involved me in the process", laments the widow. She felt neglected and thought that her position in the family was no better than that of a 'maid'. The ill treatment meted out to her started from that time.

In a massive heart attack in 1998, she lost her husband. The ill treatment towards her increased. Her sister in law made her do all the household work like cooking, washing of clothes and utensils, cleaning of the house and looking after her father-in-law. She was even forced to cook meat though she was a Hindu widow. From morning till night she was engaged in work. She hardly got any leisure. She retired at night fully exhausted. Her advancing age did not permit her to do the kind of work she used to do. Her father-in-law observed the behavior of his daughter but could not speak out, as he was terminally old. When her sister-in-law went out for work she prepared a list of work she needed to be done that day by Mukti. The emotional torture continued. One day due to inhuman physical exertion she fell seriously ill. Her sister-in-law immediately moved her to a Government hospital and informed her elder brother. All the expenses of her medical treatment were borne by her brother. For some days her brother kept her with him. When she had completely recovered she was sent to her husband's house. But her sister-in-law this time did not allow her to enter the house. She was humiliated and insulted. She went to her elder sister's house in North Bengal. There she stayed for a few months. There too she was ill treated by her nephew who always coerced her for money, which she got as her husband's pension. When she resisted he hurled foul language at her. She returned to Kolkata and decided in consultation with her brother to take respite in an old age home. She no more wanted to be a burden on any body. "As I am financially sound I can lead my own life" was the reply given by her to her brother when he gave her the proposal to stay with him. She receives a family pension of around Rs. 2000/-.

Her life has been full of agony after the demise of her husband. Psychologically she feels very lonely in life. But at the same time she is satisfied and happy in the old age home. She feels that a woman's life becomes 'a living hell' after the death of the husband.

The case above shows that after the death of the husband a woman loses her identity and respect in the family, especially if she is childless. However, financial independence does not put an end to abuse and neglect. It is the mindset of the people, which determines the status and condition of widows in society.

Case Study-V

Mrs. Nayantara Moitra is a 69 years old Hindu Brahmin widow living in an old age home for 15 years. She belongs to an upper middle class family. She did her B.A. in Bengali and is good at writing Bengali poetry. Her inclination towards writing poetry started to grow from her school days and still at the age of 69 she continues to compose. She got married at the age of 21 years. Her husband was an engineer by profession but instead of taking up a job he started his own independent business. Her in-laws were a joint family. But she could not stay in a joint family because of her husband's business. They used to live outside Kolkata in a place called Jhargram in West Bengal. Jhargram is a rural area in West Bengal. Her husband built a house there. Her husband was an owner of a huge property and assets. Thus, financially the family was in an extremely sound state.

Within two years of marriage she gave birth to three children - two sons and a daughter. She took over all the responsibility of bringing up her children. As her husband was preoccupied with his business, he hardly got any time to look after the children. The mother met all the needs of the children. She was a competent, efficient and active lady. Her two sons are well settled in their life. The elder one works in a Bank and the younger one is employed in the private sector. Her only daughter died when she was 17 years of age. Her death was very unfortunate. She went with her friends for swimming where she drowned. The loss of the daughter was a shock to her and her entire family. It took several months to overcome that shock. It had a tremendous impact on her husband. His health started deteriorating and he fell ill. During that period her two sons looked after the family business.

In course of time they got married and continued to live with their parents. In 1980 her husband died of cardiac arrest. The two deaths affected her mentally but she never expressed her emotions to her children and daughters-in-law.

After the death of her husband the situation in the house started changing. The two sons decided to live separately. They purchased a flat jointly and started living with their mother. But after the birth of their children problems arose. The daughters-in-law told their husbands that they would not take any responsibility for their mother. She had to manage on her own. She was made to cook her own food and do all her work by herself. She even washed her own clothes though they had a housemaid. Her daughters-in-law were always complaining about her to their husbands. "If I cooked, I spent more and became difficult for them to maintain the monthly expenses", said the widow. She had no communication with her daughters-in-law. If she asked any question they replied in a disrespectful tone. If some relatives visited her the daughters-in-law simply insulted her in front of them with out any reason. If she had to do any thing in the house she had to take their permission. Sometimes they passed derogatory remarks about her. As the days passed the intensity of abuse and neglect increased too. She could not stay with her sons any more. One day after consulting her sons she moved to an old age home. Her sons never opposed her decision of going there. As financially she had no problem she could look after herself.

She was forced to change her life first climbing down the social hierarchy and then compromising with the new style of life. "Once I had the control and the authority over the whole family, now after widowhood I have lost all", laments the widow. She does not blame her daughters-in-law or her sons. According to her it is the 'generation gap' that separates them from the old. At the same time no body wants to take the responsibility of old people.

She used to pay money for her stay with her sons' families. After the demise of her husband she disposed of her house and the money she received was deposited in her bank account. With the interest she pays for her own upkeep in the home. Her husband had willed all his property and assets to her. She wishes to divide the property in equal portion between her sons before her death.

The above case clearly shows that selfish and individualistic attitude of the young people takes precedence over the old in terms of love, respect, attention and affection.

Conclusion and Suggestions

The meaning and extent of older widows in India and the implications of policy and programming can be viewed from two levels:

- a) occurrence of psychological pain / neglect as a result of the widow's own response and lack of adjustment to changing social and economic systems, and
- b) occurrence of neglect, abuse, and exploitation when (compromises are made) by the younger generation in the basic values and in the treatment of elders to attain personal gains. No elder abuse reporting or adult protective service laws exist in India, nor are any research data available on the nature and scope of widow abuse here. However, mistreatment of elderly widows is frequently reported as a news item and is often reflected in the mass media. Research and development of a database on Indian aged widows experiencing widow abuse is needed to quantify the problem as well as to validate and advocate the need for funding to develop essential services.

Suggestions on the Basis of This Study

The major suggestions that emerged from the analysis of the above mentioned case studies can be grouped together as follows:

Awareness and Education : People need to be educated to perceive widows more favorably as positive contributors to society. They need to be encouraged to form closer relationships with older adults/women. This education needs to start very early, in primary school. The general population also needs to be aware that elder abuse happens and is a problem. Widows need to be aware of the problem and of their rights, as well as about available services and resources.

Intergenerational relationships : There is need to encourage a closer and more positive contact between generations. The social isolation and neglect of widows needs to be broken, through intergenerational relationships, amongst others. Also, most of the cases mentioned the perceived negative attitudes and values of the younger generation and the disrespect they show to the older generation. All of

these issues need to be addressed through education and through different programmes to build positive relationships.

Empowerment of Widows : There is need for widows to act for themselves and on their own behalf. Many participants felt strongly about the need for older adults/women to exercise their rights and advocate for their own interests.

Role of the media : The media was often blamed as one of the sources of the negative images of widows in society. It was seen as important to work with the media to change these negative images, to raise awareness and to educate the population about elder abuse and particularly the abuse of widows.

Recreation facilities : The loneliness of widows was a persistent theme throughout most of the narratives. One problem, especially in developing countries, is the lack of adequate recreation facilities. A need for recreational facilities was identified.

Structural solutions : these suggestions were less direct than some of the others, but centered around the need for strong protective laws, improved health care plans, and similar structural issues.

Counselling Services : Family focused case management and counseling with a goal to empower and support family solidarity needs to be developed.

Research: In the absence of reliable data about incidence and different forms of abuse of elderly widows, there is need for research using large and representative samples, which has scope for arriving at estimates of incidence and prevalence rates of abuse and provide deeper insights into the problem of abuse of elderly widows.

Support Services : Alternate, affordable, and adequate living facilities and support services like home delivered meals, domestic help, home visits by social workers, home nursing care, mobile geriatric services and so on are required.

The National Policy on Older Persons has given equal attention to the rights of elderly women. The National Policy assures the older persons that their concerns are national concerns and it aims to strengthen a legitimate place to older persons in the society. The policy visualizes that the state will extend support in the areas of 1) Financial Security, 2) Health care, 3) Shelter 4) Welfare 5) Protection against

abuse and exploitation 6) Opportunities for the development of older person's potential. The policy also gives special attention to older women. The recently passed act by the Central Government (Maintenance of Parents and Senior Citizens Act) recognizes that the rights of inheritance, occupancy and disposal by the widows are at times violated by their own children and relatives. It is important that protection is available to older persons. It assures to consider the introduction of special provisions in IPC to protect older persons from domestic violence.

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Elderly Widows as Victims of Physical Abuse: A Qualitative study in the state of Punjab

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ABSTRACT

The rise in the proportion of the aged has posed new challenges for both developed and developing countries. In the traditional Indian society, old people were assigned a position of respect and honour. The most important duty of the son(s) was to look after the aged parents. Failure on the part of the son(s) was considered a serious demerit and social opprobrium. Such a system provided economic, social and emotional security to the aged. Further, the institution of joint family, caste and village community which formed the building blocks of traditional structure in India, assured economic security and high social status to the aged. However, due to changing aged pyramids, value systems and withdrawal of family support system, domestic maltreatment of the elderly in India is emerging as an important social problem. The aged parents who enjoyed the higher status are now at the mercy of their son(s). The condition of widows is very serious due to their complete dependency on their sons or daughters or relatives. The widows' social circle is limited to their family. It causes a rude shock to them when they are physically abused by their sons / daughters-in-law or have to leave their families to seek support from formal agencies (Vidhwa ashrams run by philanthropic agencies) as the last resort.

Key words : Ageing, Physical violence, Dependency, Widows.

Since the middle of the 20th century, a major demographic revolution has occurred throughout the world. The number of people aged 60 and over is growing faster than all other age groups. Between 1950 and 2050, it is expected to increase from 200 million to 2 billion. The rise in

the proportions of the aged has posed new challenges for many nations, both developed and developing. The ageing trends vary between countries and regions. The speed at which population in developing countries is ageing faster than in the industrialized ones. Old age dependency poses an increasing problem in the developing world. India has the second largest number of elderly persons after China. At present it is 82 million and it is assumed that by 2050, 25 per cent of India's population will be over 60 years of age. In developing countries like India, the problem of ageing is a recent phenomenon. In traditional Indian society, old people played a dominant role in the family and community. But the changed age pyramids, new mode of production, urban way of life, formal education have brought about changes in the familial network of relationships. These changes have also affected the status and role of the aged, which has attracted the attention of social scientists in India.

An aspect of the ageing problem, the number of widows among the elderly is about 3 and a half times more than the number of widowers in India (National Human Development Report, 2001). There are 19 Million elderly women in India who are widow. Madigan (1957) hypothesized that fundamental biological differences account for male-female mortality differences in the 20th century. Gjonca *et.al.* (1999) mentioned behavioural factors such as smoking as well as medical care account for some of the male-female differences in mortality at adult age. Others have suggested that the different social roles of the two sexes affect their respective mortality rates with particular emphasis on the fact that males tend to be employed in more dangerous, harmful, stressful or difficult occupations than women. Men die earlier than women because their lifestyle (occupations, recreations) and constitution (hormones) predispose them to more traumatic situations and to more degenerative diseases or to their earlier onset (Solomos, 2000).

Older women are more likely than men to lack basic literacy and numeric skills. Majority of them belong to unorganized sectors with no pension plans, provident fund or medical cover as security in trying times. A large part of the economic contribution of the women is through household and informal economic activity. These elderly widows are often denied access to or control over resources. Also, women's inheritance rights are poorly established. The husband's resources,

including house, land and money are distributed among sons. In India widowhood is usually accompanied by a loss of status and therefore more than the loss of the husband it also means the loss of a separate identity. The older women's issues have been generally overlooked by battered women's movement. Being a woman and that too aged is a twin misfortune in the Indian context. Gender specific research in Gerontology is very significant. Aitken and Griffin (1996) argued that lack of will to intervene in elder abuse of aged women is due to the fact that older women are a disenfranchised group.

Punjab ranks among the most developed of Indian states with a high per capita income, high GDP and low levels of poverty. However, it is characterized by a highly patriarchal and feudal society wherein women are regarded as inferior beings. 50 years after independence, Punjabi women continue to feel the burden of womanhood deprived not only of access to basic facilities but even the basic right to be born. The deeply engrained patriarchal ethos limits and confines women to a subordinate role. Punjab has emerged as the most developed but least gender sensitive state of India. The state of Punjab does not carry a soft corner for the female sex. Due to patriarchal values female neglect and abuse is prevalent in all age groups. Hence it will be sheer optimism to expect holistic care of these widows in this part of the country. Punjab is fast turning into a land of old people. After Kerala, Punjab is the second state with the highest percentage of aged persons. In Punjab, the average age of women is 71 years whereas the national average is 68.01 years at present (Census, 2001). The rapid increase in the aged population has been posing new challenges at the level of the family, community, region and nation as the survival of more and more people to old age has serious demographic and socio-economic implications. When there is increased longevity and fall in infant mortality and child mortality, it results in increased dependency ratio and it adversely affects the status of the aged in the society.

Abuse and neglect of elderly widows

The WHO and the International Network for the Prevention of Elder Abuse (INPEA) define elder abuse as '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'.

Researchers in the west have tried to make a distinction between active and passive neglect while other have viewed neglect and abuse differently. Reluctance to speak of their trauma and a concern with the family's reputation coupled with a dependence on others has meant that 'elder abuse becomes known to the authorities through a third party' (Mahajan and Madhurima, 1995).

In a study of 749 elderly in Haryana, 30 per cent of all respondents admitted that quite often or sometimes they were abused by family members. Inability to work, lack of finances and failing health accounted for ill treatment (Mahajan and Madhurima, 1995). According to Kelly (2004), those elderly most likely to be abused are (1) women (2) very old (3) socially isolated in their homes (4) perceived as burdens to their families (5) living with abusers (6) in poor physical conditions and (7) likely to have become dependent on others suddenly. The abusers are characterized as (1) family caregivers (2) likely to be unemployed (3) poor and in need of money (4) feeling burdened by care giving and (5) the depressed.

The aged widows faced greater problems vis-à-vis those who had their spouses living with them. Women's status is dependent upon their husbands. After the death of their husbands they are not treated well (Nair 1980, Mahadevan and Sumangala 1986). Death of the spouse is a critical aspect of the ageing experience. Schutz (1979) proposed three basic interpersonal needs for which an individual goes for marriage, namely inclusion, affection and control. With the death of the spouse the wife is not able to transfer her needs elsewhere easily.

Older women, in particular widows, are subject to harmful practices in a number of countries, which can involve both the family and community. Due to socio-technological changes, loss of joint family, changing values, dual career families, etc., the position of elderly women has become deplorable (Ramamurthy 2003). A study conducted in Ghana found that many poor, often elderly women were accused of witchcraft. Some were murdered by male relatives and those who survived were subjected to a range of physical, sexual and economic abuses (Adinkrah 2004). Chen and Dreze (1995) observed that marginalization, social as well as physical, was usual and the widow remains highly vulnerable to neglect resulting in poor health and high mortality rates. The food discrimination, inadequate healthcare, lack of living space and excessive

expectations as far as domestic work is concerned make the elderly women's situation extremely tenuous. When these are combined with lack of access to property and assets the elderly widow's situation deteriorates. Dyer *et al.* (2000) reported that elderly abused widows have a higher occurrence of dementia and depression. Moreover, elderly persons known to have been abused physically or mentally have a significant higher mortality rates than those who have not been abused.

Theoretical Background

The belief that the dependency of elderly individuals is a major cause of abuse is widely held in literature. This largely developed from recent gerontological research on the strains on families taking care of elderly relatives. Dependency is typically defined as requiring assistance from another person or persons to continue living in the community (Pillemer, 1985). The dependency may be physical, economic, social or psychological.

Steinmetz (1988) argued that families undergo "generational inversion", in which the elderly person becomes dependent upon their children for financial, physical and/or emotional support. This places the caregiver under severe stress : "As the economic, physical, social & emotional dependency needs of the vulnerable elderly increase, the potential for abuse increases unless adequate resources are available." This is echoed by King (1989) who claims that the "dependency is the most common precondition in domestic abuse."

However, this form of dependency does not provide an adequate explanation of elder abuse. Since many of the elderly are quite dependent on their relatives, the question arises as to why some of these dependent elderly are abused and others are not? Because abuse occurs in only a small proportion of families, no direct correlation between dependency of an old person and abuse can be assumed. The reason can be the dependency of children on their elderly parents. To be free from such economic dependency the children may abuse or coerce their parents to transfer property in their names. As soon as they get their parents' property, they again start abusing them because their parents have been reduced to the status of economic dependency. One may raise the question as to how it is that the elderly assume the status of economic dependency in spite of having sufficient economic resources. They do

so because of their emotional dependency on their children. Thus they transfer the property in the names of their sons in the hope that they will be treated better if they fulfill the desires of their children.

The present paper tries to find out the relationship between dependency and abuse whether of the elderly or the caregiver. The paper has the following important features:

- First, it focuses only on physical violence. One reason for restricting the analysis to physical violence is that it is theoretically and practically distinct from other harmful coercive acts.
- Second, it is the elderly widows who are the focus of analysis.
- Third and most important, the present paper focuses on a case study analysis. For the present paper, six cases of elderly widows have been analyzed.

Objectives

- To highlight the severity of physical violence against elderly women in the family;
- To explore the reasons for the occurrence of physical violence against elderly women;
- To analyze the repercussions of such violence on the victims;
- To suggest remedial measures to minimize the occurrence of violence against elderly in the family.

Methodology

Research on abuse of the elderly widows is sparse because the problem is extremely sensitive. It becomes really difficult for the researcher to probe the personal lives of the respondents as it is kept hidden. The present paper is based on the case study method. Three cases were staying in an old age home and three elderly have been killed. On the basis of information from different family members, police records, their case histories have been prepared.

Case – I

This is a case where the caregiver manipulated to reduce the elderly mother from the status of economic independence to dependency. Mrs. D is a 75 years old widow. She has two sons and three daughters.

All the children are well educated and well placed in society. Her husband during his life time divided his property into four equal shares, i.e., one for each son, one for himself and one for Mrs. D. They had a house in Chandigarh, but after the death of her husband, her sons sold that house and divided the money between themselves. Her sons bought a new house and for that purpose Mrs. D's share as well as the share of her husband was transferred in their names. Mrs. D was treated well till her share of the property was not transferred. Once the formality was completed, she was reduced to the status of a maid servant. On small issues, she was abused verbally. It was when they started beating her physically that she decided to leave the house and seek shelter in an old age home. Her daughters are providing her the financial help. She is happy in the old age home. Her sons hardly visit her. In spite of her bitterness for her sons, her only wish is that her last rites should be performed by them.

Case – II

Ms. LD is an 80 years old widow who is the mother of five sons and three daughters. She lost her husband in an accident when her children were very small. Her husband had agricultural land, she was able to take care of her children properly. Her sons were not interested in agriculture and after attaining education took up services in the cities. Two of her sons went abroad and settled there. Three sons who were staying in different parts of Punjab compelled her to sell her land. She distributed the money equally among the three younger sons. Since none of her sons took upon him to fully support her, she was forced to stay with all her sons turn by turn for a few months. She used to work in their houses but was not treated properly. The attitude of her youngest daughter-in-law was very abusive. She used to beat her off and on. Her son always sided with his wife. Once she beat her so badly that she got a fracture on her right wrist. Till date she hasn't recovered fully. She can't use her right hand. She refused to stay with her youngest daughter-in-law. Her other two daughters-in-law got very upset with this. They have put her in the old age home. She is bed-ridden. Her sons are least bothered about her well being. She spends most of her time in reciting Gurbani and lying on the bed waiting for her death.

Case – III

Ms. KK a 70 years old widow and mother of two sons. She lost her husband 17 years back. Her sons are well settled. They were not staying with her even when her husband was alive. After his death, she continued to stay alone and was getting the pension of her husband. Four years back, she met with an accident. Her hip bone got fractured. She had to stay with her younger son and his family. She spent 6 months with them. She was completely bed ridden. Her son and daughter-in-law found it difficult to take care of her and they decided to put her in an old age home. She stayed there for three months but felt miserable. She begged her other son to take her to his house. After lot of persuasion he decided to take her to his home. She is completely bed ridden. She is kept in complete isolation and is not allowed to talk to anyone. A maid comes and does her chores. All her finances are controlled by her son. She is abused and physically beaten whenever she asks for money. Now she feels that she was better off when she was in the old age home as she was not abused there.

Case – IV

Ms. SK was 77 years old and staying with her husband in a small town in Ludhiana district. They had four daughters and a son, all married and settled. Ms. SK's son was after his parents to transfer the land to his name. However, they did not adhere to his demands. He was living separately in the village but used to come to his parents house quite often and quarreled with the old couple. Their daughters tried to intervene but the son terminated his ties with them. On and off quarrels culminated in physical violence against the couple. Many times the neighbours intervened. The couple registered a criminal case against their son. He was taken to the police station but later the police let him off with a warning after his wife came and pleaded. The couple continued to live under fear. The son would threaten his father and would borrow huge amounts of money at the time of harvesting. His misbehaviour continued in spite of intervention by relatives, friends and neighbours. Ms. SK's husband died after a brief illness. Her son's behaviour became all the more troublesome. She warned him but he did not bother and continued with his waywardness. One night when Ms. SK was alone at home her son came. They had an argument. She was thrown down

the stairs. She got severely injured with multiple fractures. Her son managed to escape. The whole night she kept on crying in pain. The neighbours contacted her daughters. In the morning when the daughters came, they took her to the hospital in the city where she succumbed to her injuries due to excessive blood loss. The daughters filed a police case. The police registered a case under section 302 IPC. The son was arrested but denied the allegation and had no regret for his actions.

Case – V

Ms. JK was a 65 year old widow who was staying with her younger son in a village of Ropar district of Punjab. She was illiterate and worked on her small piece of land. She had two sons and a daughter. Her husband had died due to alcoholism. Her children did not study and also worked as labourers. Her elder son became a drug addict, did not work and always wanted financial help from her. Whenever JK refused, the accused used to fight with her. After the death of her husband, the small piece of land was transferred to her name by her in-laws. She married all her children. But because of his addiction to drugs, the elder son's wife soon left him. JK decided to transfer the land to her sons. However, her elder son wanted a bigger share in the family property. JK refused to change her will and this made her elder son furious. He brought a country made pistol and shot his mother and injured his younger brother. JK died on the spot while the younger son sustained serious injuries. After this the elder son managed to escape but was later caught by the police. Criminal cases under section 302/25/54/59 IPC were registered against him.

Case – VI

Ms. BK, aged 78 belonged to Pakistan and migrated to Amritsar after the Partition. Her husband was a small cloth merchant. She had two sons. They were not keen on getting educated and started working at the shop with their father. When they came of marriageable age, they chose their own life partners. Their marriages created a gulf between BK and her sons. As her husband was physically fit and working it was not possible for the sons to abuse them directly. However, when BK's husband passed away due to heart attack, the sons took over the shop. The daughters-in-law started harassing her every now and then. They made her do all the household work. Whenever her

sons tried to intervene, it would lead to fight and her daughters-in-law ill-treated her all the more. She was physically abused whenever she failed to complete the household work on time. She continued to work for 8 years after her husband's death. When she became frail and could not work any longer, her sons decided to send her to an old age home. The sons did not maintain any contact with her after she came to the old age home. She has become extremely weak. Her hearing has impaired and she has been abandoned by her sons. However, she does not carry any ill feelings for them.

Analysis

From the 6 cases listed above, it becomes abundantly clear that familial relationships are no more based on love, affection and care. Instead there is an emergence of contractual and utilitarian relationships. Sons look after their aged mothers not out of a sense of respect but out of selfish motives to get hold of their property/money. As soon as they got hold over it, they started behaving differently. Whenever they were not able to get it, they resorted to homicide. It can be said that from a status of economic independence the elderly women were reduced to the status of economic dependence. As and when they became old and redundant they were thrown out of their homes.

In the present context it is to be noted that some of the elderly women became dependant on their sons merely out of love, not because their financial condition demanded it. After the death of their husbands, they expected social support from their sons. Their investment in the ideals of the family was quite high. It came as a shock to them when they had to leave their family and seek support from formal agencies as a last resort.

In Indian household the mother-in-law has a dominant role to play. She has influence on the selection of the daughter-in-law as most of the marriages are arranged. She dominates her daughter-in-law to a large extent. However, there is an other side of the picture as well. When the mother-in-law becomes a dependent on the daughter-in-law she also becomes a victim of her revenge. Such a situation is more evident in cases where the old lady is physically weak and has lost her husband. There are frequent inter-generational conflicts between the two. The son generally sides with his wife because it is she with whom

he has to spend his later life and she also looks after his children. Thus the elderly mother feels neglected due to constant tension and conflict either she leaves the family or is abandoned by the family members.

In extreme situations sons do not hesitate to beat their mothers. Physical violence against elderly parents often goes unreported since the elderly are isolated from the main stream of the society. This isolation allows violent behaviour to continue unimpeded. In a majority of cases, however, elder abuse becomes known to the authorities through a third party. Due to societal attitudes, many elderly women are too embarrassed to admit that they have raised a child capable of such behaviour.

In a number of studies it has been contended that the family no more acts as a support system to the elderly because the younger generation can ill-afford the burden of dependent elderly kinsmen as they themselves are not financially well placed (Chowdhary, 1968; Mahajan, 1987). In the present study it was noted that not only economically dependent elderly widows but also those who had property in their name were abused. The study endorses the fact that the family in India is losing one of its important functions as a support system for the elderly. A few researchers have depicted pitiable conditions of widows because of their economic, social and psychological dependency on their children (Steinmetz, 1988). The present study supports the above findings. Stoller (1983) reported that married daughters are coming forward to assume the responsibility of providing support to their elderly parents when they are abandoned by the sons. In the present study daughters showed concern for the elderly mothers. However, due to their own familial obligations they could not take care of their mothers. It is interesting to note that in all the cases it was the sons and daughters-in-law who abused their mothers. Since elderly women in Punjab have traditional sex role orientation they are bound to suffer because of their social dependency on their male children. There is, however, a ray of hope. Keeping in view the reluctance of the male children to perform their filial responsibilities it is quite likely that peoples' attitude towards the female child will change and thus brings about a change in the sex ratio in Punjab.

These findings lead to two important questions :

- What are the causes of abusers' dependency?
- Why don't elderly abused women terminate the relationship?

With regard to the first question, it can be assumed that consumerism generated by the media has played a very important role in materialistic relationships making. Thus, we can speculate that value orientation among the younger generation is more towards materialism than filial piety. Moreover, emergence of the problem of drug addiction and alcoholism in the state of Punjab is taking its toll on the youth, who under the influence of drugs and alcohol fail to distinguish between right and wrong. They do not mind killing even their own mothers for the sake of money.

The dependency theory furnishes some plausible answers to the second question. Again while definitive data is not available, the most commonly given reasons for staying with an abusive dependent relative implies that no other choice was available. These elderly women have suffered because of their social dependence on their male children whom they raised as insurance for old age. The results indicate that elderly abused mothers perceive themselves as being on the losing end of the bargain where they are giving much receiving very little. Most felt trapped by a sense of family obligation and therefore did not terminate the relationship.

What can be done to prevent elder abuse?

The impact that physical and psychological violence have on the health of an older person is exacerbated by the ageing process and diseases of old age. It is more difficult for the elderly to end an abusive relationship or to make correct decisions because of the physical and cognitive impairments that usually come with old age. In India, kinship obligations and the use of the extended family network to resolve difficulties may also lessen the ability of older people, particularly women, to escape from dangerous situations. Often, the abuser may be the abused person's only source of companionship. Because of these and other considerations, preventing elder abuse presents a whole host of problems. In most cases, the greatest dilemma is how to balance the older person's right to self-determination with the need to take action to end the abuse.

Recommendations

Although abuse of the elderly by family members, caregivers and others is better understood today than it was 25 years ago, a firmer base of knowledge is needed for policy, planning and programming purposes. Many aspects of the problem remain unknown, including its causes and consequences, and even the extent to which it occurs. Research on the effectiveness of interventions has to date yielded almost no useful or reliable results. Perhaps the most insidious form of abuse against the elderly lies in the negative attitudes towards, and stereotypes of, older people and the process of ageing itself, attitudes that are reflected in the frequent glorification of youth. As long as older people are devalued and marginalized by society, they will suffer from loss of self-identity and remain highly susceptible to discrimination and all forms of abuse.

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Books received for review

- Seven Strategies For Positive Aging** By Robert D.Hill
W. W. Norton & Company, New York, London, 2008
Price : \$17.95 USA \$ 20.00 CAN
- Social Security for the Old : Myth and Reality** By A.B.Bose Concept Publishing Company, New Delhi 110 059,
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- Workshop on Geriatrics for Physicians** from 1 to 4th February, 2009
Director Workshop : Dr. Christopher Patterson, Professor, Department of Medicine at McMaster University and Chief of Geriatric services at the Hamilton Health Sciences Canada.
Local Director : Dr. T.P.Jain, Former Professor of Social and Preventive Medicine, S.M.S. Medical College, Jaipur (Rajasthan)
- Workshop on Geriatric Nursing Care** from 11 to 14th February, 2009
Workshop Director : Dr. Sandi Hirst RN, Ph. D., GNC(C), Associate Professor, Faculty of Nursing, University of Calgary, Canada.
Local Director: Dr. Vimal Agrawal, M.Sc. (RN), Ph.D. (Former Principal, Government Nursing College, Jaipur)
Dr. K.L.Sharma, Secretary, IGA and Editor Indian Journal of Gerontology, Attended Annual NICE programme on Knowledge Exchange 2008 from 5-7th June in the University of Toronto (Canada).
He also attended 9th Global Conference on Aging (from 4-7th September 2008) organized by International Federation on Aging, Montreal, Canada. He participated in a symposium on International Collaboration for the Care of the Elderly (ICCE): Knowledge Transfer and Aging in Developing and Developed Countries.
Dr. K.L.Sharma presented his paper: Rural Elderly of India: Problems and Interventions, in the National Seminar on Ageing in India with special reference to North East India, organized by North East Center of ICSSR, NEHU, Shillong (Meghalaya) from 1-2, October, 2008.

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