

## **Elder Abuse Within the Family**

### **Statement of**

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### **Submitted to**

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Seventy-three year old Clara T. resides with her husband. She had a stroke, and experiences right-side paralysis, immobility, incontinence, and difficulty speaking. She spends most of her day in a hospital bed set up in her dining room. Her home health aide observed the following: During a routine visit, Mrs. T. began to cry, stated that she did not feel well, and asked her husband to bring her a pain reliever. Mr. T. gruffly told wife to shut up. The crying escalated. Mr. T. approached his wife with a pillow. He forcibly held the pillow over her face, angrily stating that when he tells her shut up, that is what he expects her to do. Continuing to cover her face, he roughly grabbed Mrs. T's breast.

This case, like thousands each year, was reported and investigated. I had the opportunity as a consultant to the Massachusetts Elder Protective Services Program to visit Mrs. T. and conduct a clinical assessment. I learned that Mrs. T. had experienced fifty years of domestic violence - physical abuse, emotional abuse, sexual abuse - at the hands of her husband. Her two daughters had also been abused during childhood. Mrs. T. cried as she explained, "but now it's worse." In years past her husband's work hours provided an escape from the shoving, slapping, sexual assault, and degradation. His retirement brought an end to these

respites. My comprehension deepened as Mrs. T. spoke. Prior to her stroke, she walked into her kitchen and secured the things she needed - a glass of water, medication, or something to eat. Since becoming disabled she only got what her husband was willing to bring her, when he was willing to bring it. Aside from the three hours weekly of home health aide services, she was completely dependent upon her abuser for the necessities of life. Tears streamed down her face as she described humiliation when her husband changed her soiled clothing and washed her. He often took sexual advantage at these times. Caring for her made him angry. He claimed she had wrecked his golden years by having the stroke. He dressed, bathed, and fed her with rage.

I thank the Committee for giving me the privilege of presenting some of what I have learned from my clinical work and research with hundreds of older victims like Mrs. T. As a mental health clinician, social worker, and sociologist, I have worked with family and interpersonal violence for a quarter century. For the past 14 years, my work has focused on elder abuse.

Abuse of elderly people in nursing homes and other long-term care settings is shocking and intolerable. It is important to realize, however, that most of our seniors reside in the community. The problem of elder abuse in the community is significant, and demands our attention and resources. For example, during the most recent fiscal year in Massachusetts, three times as many elder abuse cases were investigated and substantiated in community, as opposed to facility, settings. Most community-dwelling victims are abused by family members. A study of 130 cases investigated for suspected sexual abuse of elders residing in the community found that 77% of the alleged offenders were members of the elder's family (Ramsey-Klawnsnik, forthcoming).

The nature and consequences of abuse become more serious during advanced age due to diminished health and increased susceptibility to injury. Like Mrs. T., many seniors victimized by family members have endured long-term domestic violence. Others experience onset of family violence during senior years after becoming disabled.

For example, eighty-six year old Mrs. J. moved into the home of her daughter and son-in-law to recover from a broken hip. Several months later, her daughter died and her son-in-law became her caregiver. Mrs. J. disclosed to her visiting nurse that he took nude photos of her. He undressed her and instructed her to open her legs and smile for the camera. He said the photos would provide evidence that he had not abused her and that her daughter would want her to cooperate. He also “checked” her genitals by inserting objects. In addition, she was forced to sign papers without opportunity to determine the content. Upon investigation, sexual, emotional, and financial abuse was substantiated. The forcibly signed papers named the son-in-law as Mrs. J.’s life insurance beneficiary. Mrs. J. was helped to move out of the home and cooperated with the ensuing criminal prosecution. This abuser earned his living as a Home Health Aide.

Much is required to end abuse and help victims like Mrs. J. recover. First and foremost, suspicious cases must be recognized and reported. Protective services staff must competently investigate allegations, respond to crisis situations and provide case management. Medical/nursing/mental health forensic experts are needed to evaluate suspected cases, document evidence of inflicted harm, and formulate treatment plans. Ongoing medical and mental health services are often needed to help victims heal. Law enforcement officers and prosecutors trained to accommodate the special needs of victims with disabilities are required for proper criminal justice response. Legal representation and, in some cases, guardians or fiduciaries are needed to insure protection of rights. The concrete needs of victims are many. They range from emergency shelter and permanent housing, to food, medicine, transportation and assistive devices. Victims with disabilities may require personal assistants to feed, bathe, dress, and otherwise care for them, particularly if their only alternative is exploitative relatives to meet basic needs.

Are there adequate resources available to assist victims? No - unmet needs abound! Caring helpers scramble to secure scarce resources and payment mechanisms and piece together solutions for victims. Budgets and eligibility requirements are tight and getting tighter. Many victims do without.

There is an army of trench workers across America struggling daily with unmet victim needs. This is the staff of our Elder and Adult Protective Services Programs. I have had the opportunity to teach and to learn from protective services staff across the country in my frequent role as clinical consultant and staff development trainer for these systems. I can personally attest from my site visits that from Florida to Oregon, Texas to New Hampshire, Hawaii to Massachusetts, as well as in-between, protective services programs have insufficient resources to fulfill their mandate: to protect and serve those who are elderly, disabled, and abused.

The lack of adequate funding is pervasive and disturbing, and the consequences are significant. Staff salaries are low and caseloads are high. Workers are insufficiently trained and supported to skillfully handle the myriad of complex problems, allegations, and emergencies confronting them unceasingly. Research of the National Association of Adult Protective Services Administrators found that 47% of the 36 states participating in the study have no annual training budget for their protective services staff. In two-thirds of these states, new workers are dispatched into the field before completing basic training.

As a group, protective services staff are committed, compassionate, hard working and resourceful. They venture into dangerous homes and neighborhoods to investigate reports. They tread slowly even while rushed and overworked to gain the trust of victims. They scour their communities in search of resources for their clients. They carry beepers which interrupt their sleep, go out into the dark night to respond to emergencies, and take urgent reports of suspected abuse while the rest of us enjoy family dinners on holidays.

Protective service supervisors, managers, and administrators try to work magic with inadequate budgets, spreading resources as fairly and as far as possible. They make the hard decisions: Which case to open? Which case to close? How to get other professionals to help victims with little money to purchase required services? How to keep quality staff when inadequate compensation is offered?

Protective services staff require advanced and specialized training. They must be skilled in many areas to effectively respond to suspected and confirmed abuse. A wonderful conference takes place in San Antonio - the Annual Adult Protective Services Conference. Experts from many disciplines are brought in

from around the country to provide state-of-the-art information. Alas, most workers cannot afford to attend, and their employers cannot afford to send them. This is but one of countless examples of the unmet needs of those on the front line in the inadequately financed war against elder abuse.

The abuse perpetrated by Mrs. J.'s son-in-law suggests a similarity between elder and child abuse. Child abusers frequently abuse more than one child and seek positions of authority over potential victims. Those who abuse within the family often abuse outside of the family as well. It is reasonable to assume that elder abusers are similar. The psychology of the elder abuse offender has not been researched. We know from case reports that these offenders frequently engage in multi-faceted abuse. Elders harmed by physical abuse, for example, are at high risk of also sustaining other types of victimization. Research is lacking to adequately tease out the relationships among those who abuse children, spouses, adults with disabilities, and the elderly. We do know from casework with victims like Mrs. T. that many offenders harm individuals across these categories.

Scientific study of elder abuse is in its infancy. The unknown greatly exceeds the known. How common is it? Who is most at risk of being victimized or of offending? Why do people abuse vulnerable elders? How can this be prevented? What are best practice methods for investigation, intervention, and prosecution? What mental health treatments are effective to reduce post-traumatic victim suffering? The research needs are extensive. For example, there has not been a national, prospective study of sexual abuse of elderly people. How can we successfully intervene without scientific knowledge? Do victims deserve to have us show up ready and willing to help, but without the benefit of social science findings to inform our efforts? I think not.

I have long been a member of the National Committee For the Prevention of Elder Abuse. In recent years, I have had the honor of serving on the committee's board. I have learned much from my esteemed colleagues on the board representing fields including medicine, law, criminal justice, social policy, research, aging and social services. The greatest lesson has been the critical need for interdisciplinary collaboration in responding to elder abuse. No one group can handle this alone. This widespread, serious problem requires the expertise of many. Training is needed for the wide array of professionals who must work

cooperatively when victims need their help to find safety and justice.

Elder abuse victims rely upon their service providers to respond to their plight with kindness, knowledge, and competence. Victims, and the people working on their behalf, also rely upon our elected representatives to respond with kindness, knowledge, and competence. I applaud you for holding these hearings to learn about this problem. I support and applaud efforts to fund the enormous work required to adequately respond to elder abuse. I urge you, honorable leaders, to support the Elder Justice Act. Based upon my experiences at the bedsides of people like Mrs. T, in training sessions with protective services staff, and in conference rooms with cross-disciplinary professionals seeking answers to hard questions, I can promise you that the Elder Justice Act will help. If passed, this legislation will make a real difference in what we can offer older victims. Thank you for your kind attention and interest in this disturbing social and family problem.

For further information, please see:

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