

Forum

Community Elder Mistreatment Intervention With Capable Older Adults: Toward a Conceptual Practice Model

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Abstract

Community-based elder mistreatment response programs (EMRP), such as adult protective services, that are responsible for directly addressing elder abuse and neglect are under increasing pressure with greater reporting/referrals nationwide. Our knowledge and understanding of effective response interventions represents a major gap in the EM literature. At the center of this gap is a lack of theory or conceptual models to help guide EMRP research and practice. This article develops a conceptual practice model for community-based EMRPs that work directly with cognitively intact EM victims. Anchored by core EMRP values of voluntariness, self-determination, and least restrictive path, the practice model is guided by an overarching postmodern, constructivist, eco-systemic practice paradigm that accepts multiple, individually constructed mistreatment realities and solutions. Harm-reduction, client-centered, and multidisciplinary practice models are described toward a common EMRP goal to reduce the risk of continued mistreatment. Finally, the model focuses on client–practitioner relationship-oriented practice skills such as engagement and therapeutic alliance to elicit individual mistreatment realities and client-centered solutions. The practice model helps fill a conceptual gap in the EM intervention literature and carries implications for EMRP training, research, and practice.

Keywords: Abuse, Neglect, Response programs, Theory

Elder mistreatment (EM) is a pervasive problem with major consequences to the elder victim and society. EM refers to action or lack of appropriate action occurring within a relationship of trust that causes harm or distress to an older adult ([World Health Organization, 2008](#)). Each year, 7.6%–9.5% of community-dwelling, cognitively intact adults aged 60 years or above experience some form of mistreatment ([Pillemer, Burnes, Riffin, & Lachs, in press](#)). Barring the development of effective primary prevention, EM cases will nearly double over the next 15–20 years in proportion with the growing senior population. The number of EM cases reported to authorities is rising as more states have adopted mandatory reporting laws ([U.S. Government Accountability Office, 2011](#)).

EM is associated with shortened survival, hospitalization, emergency room visits, nursing home placement, psychological disturbance, and poor health ([Dong, 2013](#)).

The convergence of high incidence rates, increased reporting, and a growing senior population is culminating into growing pressure on our systems responsible for addressing EM. Adult protective service (APS) caseloads are growing nationwide and agencies lack the necessary information to respond appropriately ([U.S. Government Accountability Office, 2011](#)). Our knowledge and understanding of effective response interventions represents the largest gap in the EM literature ([Ernst et al., 2013](#)).

At the center of this gap in EM intervention knowledge is a lack of theory or conceptual models to help guide

research and practice. Theoretical models have been developed to guide our understanding of EM risk factors in the general population (Jackson & Hafemeister, 2013). Process map and logic models have been constructed to describe the structure and processes implemented by a multidisciplinary elder abuse forensic center (Navarro, Wilber, Yonashiro, & Homeier, 2010; Navarro et al., 2015). However, practice-focused theoretical models are unavailable to guide practice and research in programs that directly respond to, support and protect EM victims. APS documentation outlining recommended practice guidelines and principles is available (National Adult Protective Services Association Education Committee [NAPSA-EC], 2013); however, recommendations are not grounded in a theoretical basis. Theory provides practitioners with a conceptual rationale for intentional practice. Without understanding the epistemological paradigm and theoretical perspectives informing practice, we cannot organize a congruent research effort toward effective interventions. The purpose of this article is to develop a conceptual practice model for community-based EM response programs (EMRPs). For the first time, EMRP practice is understood through a theoretical lens.

For this article, EMRP refers to community organizations/programs responsible for working on the front-line directly with EM victims toward the overall objective to prevent or reduce the risk of revictimization. For the vast majority of U.S. states, EMRP refers to state or locally administered APS programs. In select areas, such as New York City, EM cases involving cognitively intact victims are handled by community-based programs such as the Jewish Association Serving the Aging Legal/Social Work Elder Abuse Program (JASA-LEAP; Rizzo, Burnes, & Chalfy, 2015) or the New York City Department for the Aging Elderly Crime Victims Resource Center (Sirey et al., 2015). Specific administrative structures and practice parameters differ across APS settings throughout the country and between the aforementioned EMRP types. However, EMRPs share a common overall goal to eliminate or reduce the risk of continued elder abuse and/or neglect. As it relates to work with cognitively intact older adults, EMRPs also share fundamental tenets that anchor the nature of practice and transcend EMRP type, including the voluntary nature of services, client self-determination, and the imperative to pursue the least restrictive intervention path.

The conceptual practice model in this article was developed to include epistemological, theoretical, and practice perspectives that inform and align with core EMRP practice principles for work with cognitively intact EM victims. It is not intended to inform EMRP practice with older adults who lack cognitive capacity, because these clients are exposed to a different set of practice guidelines in which foundational tenets of self-determination and voluntariness do not necessarily apply. The purpose of the model is to provide a conceptual lens that informs practice for individual EMRP practitioners as well as the overall culture and philosophy of practice at the EMRP organizational level.

The model also carries indirect relevance to professionals and EM multidisciplinary teams who do not work directly with the victim but work alongside EMRPs in a third-party or consulting role. The conceptual practice model is meant to inform the nature of the EMRP client/practitioner relationship and EMRP service/treatment planning and evaluation/outcome measurement processes. At this nascent stage in the scholarly development of conceptual EMRP practice models, the proposed model does not differentiate between different types of mistreatment. It is built upon core principles intended to be applicable to practice with all EMRP clients.

The model structure is adapted from Bogo's (2006) conceptualization of practice knowledge, which integrates three levels of knowledge: explanatory or grand theories, intervention models, and practice principles/skills. Using this approach, a comprehensive conceptual practice model ought to contain continuity and integration between these three levels of knowledge. Similarly, the practice model in this article follows a top-down organizational structure in which overarching epistemological/theoretical perspectives inform specific practice models and techniques/skills. The model also relates the proposed practice orientation to success on key EMRP outcomes (Figure 1).

Foundational EMRP Tenets: Voluntariness, Self-determination, Least Restrictive Path

In developing the model, a key goal was to maximize parsimony. Several practice principles are embedded within the culture of EMRP practice (NAPSA-EC, 2013). However, three principles in particular are influential in shaping the EMRP practice paradigm and the tenor of the model, namely voluntariness, self-determination, and the imperative to pursue the least restrictive intervention path.

EMRP services are voluntary, unless the older adult lacks cognitive capacity. Therefore, cognitively intact clients can choose to accept EMRP services completely, partially, or refuse services altogether. Refusal or underutilization of services is a major problem. Up to 96% of EM victims living in the community do not use formal support services (Lachs & Berman, 2011). Among EM victims who interface with EMRP programs, approximately 13%–58% refuse services completely. Among clients who accept some level of EMRP support, only 16%–28% pursue all interventions recommended in their service plan (Ernst et al., 2013; Rizzo et al., 2015). The voluntary nature of EMRP services and the realistic risk of client attrition lie at the forefront of clinical practice.

Running parallel to voluntariness is the tenet of an older adult client's right to self-determination. Elder victims of mistreatment have the right to determine their own fate and course of action that fits within a personal purview of what is deemed appropriate and desired. The older adult has a right to make their own decisions, even if these decisions impede or counteract the goal of safety. Perhaps the

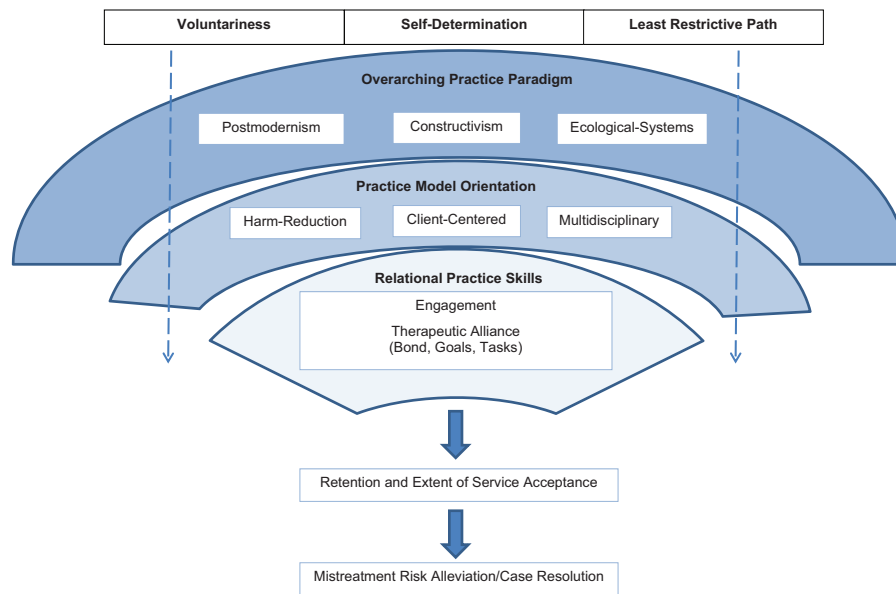


Figure 1. Conceptual practice model for direct work with cognitively intact victims of elder mistreatment in the community.

greatest moral challenge faced by EMRP practitioners is the act of balancing the pursuit of safety with the client's right to self-determination. Related to this balance is an imperative to pursue the least restrictive intervention path. An EMRP service plan ought to reflect a plan of action that limits the older adult's rights/freedoms and imposes intrusions to the least extent possible while pursuing the goal of mistreatment risk alleviation.

Overarching Practice Paradigm

The general practice paradigm in EMRP settings can be understood through the lens of three epistemological/theoretical orientations: postmodernism, constructivism, and ecological systems.

Postmodernism

Postmodernism represents an epistemological orientation that emerged in the late-20th century in reaction to the modernist/positivist belief that reality can be explained by universal truths. A modernist practitioner might approach a problem as an authoritative expert with a prefixed definition of what the problem means and who directs the client toward an accepted or uniformly defined outcome construct of success (Dean, 1993). Conversely, a postmodern paradigm accepts multiple realities and solutions across individuals and focuses on the relative truths of each person. A postmodern orientation is skeptical of presumptions that claim to be valid for everyone and dismisses the notion that there is a universal truth to be pursued (Schindler, 1999). EMRP practice with cognitively intact older adults is driven by a postmodern orientation in that there is no predetermined, standard construct of the EM problem, solution, or the means of reaching a solution. Elder clients

attribute varying meaning and perceptions to the mistreatment problem and have different, individually constructed notions of what a successful case outcome looks like. EMRP practitioners recognize that multiple solutions exist to alleviate EM, which depend on the self-determined perceptions and unique circumstances of the client. Although few clients seek to eliminate the risk of revictimization (e.g., by severing ties with a perpetrator), the strong majority of clients seek a construct of case resolution that reflects a reduction in risk—one that increases safety yet may also preserve family relationships or protect a familial abuser from legal/justice systems. EM cases are heterogeneous in regards to the nature of mistreatment, the circumstances informing risk of revictimization, and the meaning attributed to a successful outcome (D. Burnes & Lachs, 2015).

Constructivism

Constructivism is an epistemological position that aligns closely with the postmodern assumption of multiple realities. Using a constructivist lens, individuals are active participants in the interpretation and construction of their own reality (Dean, 1993). Victims of EM do not passively absorb some standardized blue print of the EM experience, but rather they participate in the construction of an individualized version of what mistreatment means. The multiple truths that exist across EM victims in relation to the mistreatment problem are individually and socially constructed based on the unique history, sociocultural context, and interpersonal dynamics surrounding the EM situation, as well as intrapsychic/cognitive processes that attribute meaning. A constructivist orientation encourages an inductive course of action in which conclusions about a problem are generated from the information at hand, as opposed to a deductive approach that positions presenting data against

pre-existing categories or assumptions (Schindler, 1999). The EMRP practitioner is not presumed to be objective or distanced from the client but rather becomes an active participant in the construction of meaning (Saari, 1991). The EMRP practitioner is challenged to understand a given EM situation through the client's worldview and take an active role in co-constructing a plan of action that fits within the parameters of that client's relative truth.

Ecological Systems

The eco-systems perspective has gained momentum over the past couple of decades as a way to understand EM (National Research Council [NRC], 2003; Schiamberg & Gans, 1999). EM is influenced by several causal mechanisms, as opposed to originating in a single etiological process (NRC, 2003). Single theories are either too narrow in scope or incapable of linking the multilayered systems surrounding most EM situations (McDonald & Thomas, 2013). Using an eco-systemic perspective, risk of EM revictimization can be viewed as a function of multiple, interacting domains that represent various levels of social organization, including factors attached to the individual victim (e.g., functional status, health status) and perpetrator (e.g., mental health, substance use), victim-perpetrator relationship (e.g., social relationship type, power dynamics), family system (e.g., implicit hierarchies, intergenerational patterns), home living environment (e.g., cohabitation status), social embeddedness (e.g., social support/network and surveillance), and the victim's intersection with broader sociocultural arrangements/processes (e.g., gender, race/ethnicity, socioeconomic status; NRC, 2003).

An eco-systemic perspective provides EMRP practitioners with a multidimensional assessment framework to understand the full scope of factors contributing to the risk of revictimization. It informs the need to target systems beyond just the individual victim to alleviate mistreatment risk, such as interventions that integrate the perpetrator and larger family system or that seek to alter the home living environment and broader social support network.

Practice Model Orientation

EMRP work with cognitively intact older adults can be characterized by the following general practice orientations: harm-reduction, client-centered, multidisciplinary. These practice orientations follow from the underlying assumptions of paradigms outlined above including multiple, individually constructed mistreatment realities that exist within complex ecological systems.

Harm-Reduction

A harm-reduction practice orientation carries the primary aim to alleviate harm (Riley & O'Hare, 2000). EMRPs work within a harm-reduction model in that they are not

necessarily seeking to eliminate or completely resolve the risk of revictimization, depending on the client's construction of a successful outcome. In the majority of cases, the goal is to reduce risk by pursuing the least restrictive intervention path. A harm-reduction approach recognizes that, in reality, EM cases are rarely ever completely resolved; it is nearly impossible to achieve the absolute, close-ended outcome of mistreatment risk cessation. Such an outcome would involve a permanent extrication of the victim and/or perpetrator from the EM circumstances and severing of the victim-perpetrator relationship. Forceful removal of the victim or perpetrator and an imposed relationship severing would not correspond with the voluntary nature of services. A harm-reduction approach allows for the realization of varying, self-determined solutions that exist along the full spectrum of risk reduction. A harm-reduction model also reconciles the morally challenging EMRP practice reality that some elder clients will choose an intervention path that continues to carry considerable risk of revictimization.

Client-Centered

A client-centered practice orientation clearly aligns with the notion of addressing individually constructed mistreatment realities. A one-size-fits-all EMRP intervention approach across all clients would not be feasible in a context where clients have widely varying needs and target end-points. EM cases are heterogeneous and require client-centered solutions along individualized paths of intervention. Each EM case requires a unique combination of service plan interventions to achieve the goal of risk alleviation. The constellation of interventions composing a given service plan depends on the client's wishes and the distinct circumstances surrounding the EM situation (e.g., EM type, victim proximity to perpetrator, level of social isolation, etc.; D. Burnes, Rizzo, Gorroochurn, Pollack, & Lachs, 2014). Although EMRP service plans are uniquely developed around a client's specific needs and perceptions, a client-centered approach does not preclude the possibility of designing specific, evidence-based EMRP interventions that target particular client issues (e.g., support group to empower victims with low self-esteem, restorative justice intervention for perpetrators). Any one intervention cannot be applied to all cases; however, a select intervention could be included as a component in several case plans that share a similar need.

Multidisciplinary

A multidisciplinary practice orientation has received the greatest amount of empirical support in the EM literature (Navarro, Gassoumis, & Wilber, 2013; Rizzo et al., 2015). A multidisciplinary approach provides the necessary diversity of professional resources and skills, used at different points along the assessment and intervention process, to problem-solve and address multifaceted cases of EM. It is

not uncommon to require the respective, specialized services and skill sets of social workers, lawyers, law enforcement, and/or geriatric health care providers in order to assess and respond to the various aspects of a given EM case. An integrated and coordinated multidisciplinary approach facilitates greater service delivery efficiency, as opposed to navigating through a silo system of disconnected disciplines and services (Navarro et al., 2015). A multidisciplinary practice model has been successfully integrated and implemented in select community-based programs, such as JASA-LEAP (Rizzo et al., 2015). Full integration of multidisciplinary services into a centralized APS program is more challenging and the extent of multidisciplinary integration varies across APS settings. Some APS agencies have in-house legal services and/or geriatric specialists, whereas others coordinate with these specialized services externally. It is not uncommon for APS agencies to have close working relationships with external law enforcement and the District Attorney's office. The model suggests that EMRPs should strive to integrate multidisciplinary practice to the fullest extent possible.

Practice Skills

Within the context of a postmodern, constructivist practice paradigm and in the absence of evidence-based intervention research, the conceptual practice model emphasizes relationally based EMRP practice skills rather than specific intervention techniques. Emphasis is placed on the importance of a two-way client-practitioner interaction built on qualities of mutuality and collaboration, rather than a one-way practitioner-to-client-guided dynamic directed by presumed practitioner expertise (Dean, 1993). A postmodern, constructivist practice paradigm views the client/practitioner relationship as a space in which the client's experience is given meaning (Simpson & Williams, 2007). The client/practitioner relationship can provide a safe holding environment to challenge existing detrimental norms and a trusting base from which the client may be willing to pursue new cognitions and behaviors (Schore & Schore, 2008). The quality of the client/practitioner relationship represents a common process factor that accounts for substantial variation in case outcomes, often more than the specific intervention type/technique employed (Duncan, Miller, Wampold, & Hubble, 2010). Neuroscience evidence indicates that client change is facilitated through interpersonal/relational connection with the practitioner (Fishbane, 2007). In particular, engagement and therapeutic alliance are client/practitioner relationship-level factors that predict client retention and successful case outcomes in other social service domains, including child protection, mental health, and addictions (Dearing, Barrick, Dermen, & Walitzer, 2005; McKay et al., 2004; Yatchmenoff, 2005). These skills have been given very little attention in the EM intervention literature.

Engagement refers to a process in which a client formulates initial perceptions about trust, rapport, and relationship quality (Yatchmenoff, 2005). Client engagement

is particularly important to EMRP practice since services are voluntary and clients are often resistant, not eager, to involve an EMRP in their life. There are several reasons that EM victims choose to remain hidden from or resist EMRP involvement, including a fear of perpetrator retaliation, prioritizing family preservation over personal needs; guilt, shame, or denial; stigma; economic or functional dependence upon the perpetrator; a desire to maintain the status quo at later stages of life; and so forth. Older adults from ethnically/racially marginalized communities may have distrust toward social service agencies, language barriers, or vulnerability attached to immigration status. The EM may be grounded and normalized in long-standing power and control or unequal family dynamics. A refusal of EMRP services may be motivated by parental instincts to protect child/grandchild offspring perpetrators.

The ability to engage different older adult victims of EM who have varying relational needs is one of the most challenging, yet critical skills in EMRP practice. It requires intangible meta-competencies such as adaptability, social intelligence, creativity, genuineness, and warmth (Bogo, Rawlings, Katz, & Logie, 2014; Sprenkle, Davis, & Lebow, 2009). It is also possible to elucidate tangible engagement skills, such as emphasizing certain words in the initial phone call (McKay et al., 2004) or inquiring about family pictures hanging on the wall during the first home visit (Holt-Knight, 2015). The quality of engagement likely helps differentiate those clients who accept or refuse services.

As an extension of engagement, the therapeutic alliance between client and practitioner represents the foundation of practice and major vehicle facilitating change. The therapeutic alliance refers to the quality and strength of the collaborative relationship between client and practitioner (Sprenkle et al., 2009). In the EMRP context, without establishing a trusting and collaborative client-clinician relationship, the client is less likely to feel safe or willing to take steps toward the realization of safety.

The therapeutic alliance is conceptualized as consisting of three components: bond, goals, and tasks (Horvath & Greenberg, 1989). Bond refers to the level of affective connection between the client and practitioner. Clinical skills contributing to the formation of a bond include empathy, attunement, warmth, congruence, genuineness, and the practitioner's ability to convey competence. The development of client-clinician bond also evolves out of the process of reaching joint understanding on goals, expectations, and the tasks that will be undertaken to reach goals (Sprenkle et al., 2009). Given the voluntary nature of EMRP services and emphasis on client self-determination, the practitioner must be capable of collaborating with the client to co-construct meaningful and mutually agreed upon goals, expectations, and tasks.

Outcomes and Measurement

The conceptual practice model informs short-, intermediate-, and long-term EMRP outcomes. Short-term outcomes

include the extent of client/practitioner engagement and therapeutic alliance. Established measures of engagement and therapeutic alliance, respectively, include the Client Evaluation of Self and Treatment engagement subscales (Joe, Broome, Rowan-Szal, & Simpson, 2002) and the Working Alliance Inventory (Horvath & Greenberg, 1989).

The model practice orientation has been developed to facilitate success on the intermediate EMRP outcome of client retention. Short-term engagement and therapeutic alliance contribute to the likelihood of retention. Retention is typically operationalized as a dichotomous service acceptance/refusal outcome. However, service acceptance occurs along a continuum in EMRP settings. Importantly, the extent of client acceptance along this continuum ultimately predicts level of case resolution (Rizzo et al., 2015). D. P. Burnes, Rizzo, & Courtney (2014) developed a comprehensive way to measure the extent of client service acceptance, which controls for differences across cases in both the number of service plan interventions and the completion-difficulty level attached to each intervention.

Success on the aforementioned short (engagement, therapeutic alliance) and intermediate (retention, service acceptance) outcomes contributes to success on the main EMRP intervention outcome of mistreatment revictimization risk alleviation (or case resolution). The epistemological orientation of the conceptual practice model indicates a need for measurement strategies capable of capturing individualized trajectories of change and a heterogeneous case resolution outcome construct. Standard risk measures that apply the same set of items to each case may miss client-specific salient risk elements or include a host of irrelevant/static items that dilute meaningful change. Goal attainment scaling is one measurement strategy capable of detecting individualized change and accommodating construct flexibility on the outcome of case resolution (D. Burnes & Lachs, 2015).

Future Research

The next step in the development of the proposed conceptual practice model is to test its validity and reliability against empirical data and, in turn, determine whether modifications are necessary (Jackson & Hafemeister, 2013). To begin, the epistemological, theoretical, and practice orientation of the model should be compared with the practice mentality employed by EMRP practitioners. Qualitative research could be used to verify whether the model orientation reflects an accurate practice lens of EMRP practitioners. Simulation-based research could be used to observe how EMRP practitioners operate in simulated practice scenarios and the extent of fit with the model (Bogo et al., 2014). The proposed model also contains implicit hypotheses that should be tested in different settings and with repetition over time to evaluate its validity and reliability. Hypotheses generally relate to the virtues of a postmodern, constructivist and eco-systemic practice orientation in

facilitating favorable client outcomes of retention, extent of service acceptance, and mistreatment alleviation. Select important hypotheses include:

1. A two-way, collaborative client/practitioner working relationship leads to better outcomes than an authoritative/directive practitioner-to-client approach.
2. Higher levels of client/practitioner engagement and/or therapeutic alliance will lead to greater retention, service acceptance, and mistreatment alleviation.
3. A multisystemic intervention approach that incorporates the perpetrator and relevant family members leads to better outcomes than an approach that only focuses on the victim.
4. A harm-reduction-informed practice approach results in better outcomes than a mistreatment cessation-informed approach.
5. EMRPs that internally integrate multiple disciplines have better outcomes than EMRPs that coordinate with multiple disciplines externally.

Limitations

The conceptual practice model was developed to align with shared practice principles across EMRP types. However, compatibility issues will arise depending on the specific organizational structure and practice constraints of individual EMRPs. It is possible that the model most readily fits within domestic violence or mental health-oriented EMRP settings and that compatibility issues are more likely to arise in APS settings governed by state or locally legislated constraints. The model does not apply to APS in jurisdictions where APS only serves vulnerable older adults with cognitive impairment. Although postmodern, constructivist-oriented assessment approaches exist (Dean, 1993), these model orientations do not readily fit with the priorities of initial phases of EMRP investigation and assessment. These initial phases require standardized protocols and assessment tools to promote consistent decision-making across cases in regards to substantiation/un-substantiation and determination of response priority. The model is not exhaustive in regards to the theory, practice orientations and skills that could potentially be applied to the EMRP context. The intention was to develop a broad-stroke, parsimonious conceptual model with greater generalizability, as opposed to a highly detailed model. The proposed model is open to iterative development based on future research. It is likely that more detailed, distinctive EMRP practice models will develop in relation to different types of mistreatment as new research arises to inform such diversification.

In conclusion, this article attempts to fill a conceptual gap in the EM intervention literature. The lack of progress in EMRP intervention research is widely recognized (Ernst et al., 2013; Pillemer et al., 2015). The proposed model provides a conceptual basis to help organize a cohesive research effort and inform complex everyday EMRP practice.

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