Review Article

Classifying Elder Abuse – A Review

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ABSTRACT

Existing geriatric sciences, particularly psychology, should foresee the future geriatric problems among which Elder Abuse (EA) will be challenging since geriatric patient practice is bound to increase drastically in coming decades. Currently one of the initial steps that demand to be initiated is to set a framework about which scientific refinements will be taken according to future research. The aim of this exhaustive review is to recognize categorization of EA, which ranges within the causes to the management while similarly identifying its various divisions. A systematic search on 7 different medical electronic databases identified about 1782 articles with relevant headings and subheadings, from which around 145 articles were found to be relevant to the present review. Multifaceted, complex, dynamic and interrelated characteristics of EA were identified from which different subclasses and categories with common features were grouped to produce a categorization scheme. Management of different types of abuses requires different approaches at the individual, professional and community level which have also been discussed.

INTRODUCTION

With life expectancy having increased from forty years in 1951 to sixty four during present times, older people are the fastest growing segment of the population globally. An age termed in French as "La troisieme age" (the third age), predictions indicate that by 2030 (U.S. Bureau of the Census), the population over age 65 will double to more than seventy million people and older people will make up almost twenty percent of the population in the united states alone [1]. Whereas at the same time it will triple globally within the next few decades (from 672 million in 2005 to nearly 1.9 billion by the year 2050 [2]. Countries like Japan and Sweden will have 17% of their population falling above sixty five years of age [3], whereas in developing countries more than double by 2025, reaching 850 million– 12% of the overall population of the developing world – though in some countries, including Colombia, Indonesia, Kenya and Thailand, the increase is expected to be more than fourfold [4]. With such a vast geriatric population going to be dependent on youth, the outcome of Elder Abuse (EA) can be only foreseen. From been mentioned in Roman literature to Shakespeare's reflection of King Lear's message to his daughter Cordelia [5], EA is a subject of relationships gone awry. First medical literature to give notice to EA, is the case of "granny battering" that came in 1975 [6] from England where there was no question that the battering was deliberate. Since then, different terminologies have been used to coin EA which includes elder mistreatment, elder neglect and elder

maltreatment. American Medical Association (AMA) in 1987 defined [7] EA as “an act or omission which results in harm or threatened harm to the health or welfare of an elderly person.” For the present review, we chose to include definitions given by EA prevention, identification and treatment act (1985) [8], Johnson (1987) [9], Fulmer and O’Malley (1987) [10], Hudson (1989) [11], Johns et al (1991) [12], Bonnie and Wallace (2003) [13] and Lowenstein (2009) [14]. This broadened the scope of finding subclasses among categories. This literature review is a part of a clinical research in which the impact of EA upon prosthetic treatment was analyzed. Since the classification of EA is conspicuously scarce in the literature except for one non-English research in 2016 [15], the objective of the present review is to provide a scaffold for further classifications in the subject of geriatric abuse.

MATERIAL AND METHODS

The main study was initiated by procuring ethical clearance from the ethics committee of the University, which conducts studies in accordance with Helsinki Declaration [16]. We conducted a systematic and organized search on seven medical electronic databases (Pubmed, PsycINFO, Google scholar, Scopus, MEDLINE, Scopus, Proquest), besides extending search on various other search engines to include grey literature (Google, Yahoo, Bing, Ask) using specific terms like EA, elder neglect, elder maltreatment, parent neglect, parent maltreatment, classification, geriatric abuse, exploitation of elders, elder mishandling, elder homes, elder hospital problems and many other non-specific but related terms. The primary focus while selecting the articles from the electronic database was on the variables associated with different types of EA. Relevant papers were selected after screening of titles, abstracts and manuscript text by independent reviewers. In the next phase, relevant articles were screened for cross references which was procured following another search. Multiple searches resulted in the isolation of 1782 articles that included trials, qualitative and quantitative studies, empirical studies and cross sectional surveys, government and non-government organization reports, guidelines, thesis and literature reviews. Final selection, however comprised of 145 articles which were pertinent to developing a classification system. Inclusion criteria for research articles included community based samples providing abuse prevalence at national/international level, studies conducted on participants aged 60 years and above, non-authenticated press reports while excluding qualitative method studies, conference proceedings and studies based on self-neglect.

DISCUSSION

A bird’s eye view of the studied literature shows that EA reports dating back to the eighties when first large scale random sample survey of 2020 community dwelling elderly persons in Boston showed a prevalence of overall maltreatment of 32 persons per 1000 elderly individuals [17]. Since then available estimates in year 2010 have shown that between one and two million Americans (=65) have experienced abuse in one form or the other which is otherwise less because of non reporting. 2 While in the year 2000, documented cases of elder maltreatment reached to six lakhs in the United states alone [18], a meta-analysis of 51 studies in 2017 revealed a pooled prevalence estimate to be 10% and 34.3% in population based studies and third party or caregiver reported studies respectively [19]. EA traditionally, takes form of being physical, sexual, psychological (neglect), financial exploitation and violation of elderly rights [20]. Besides these, other forms exist like material and fiduciary abuse, financial exploitation, financial mistreatment, economic victimization [21,22], considered for granted or as a domestic servant, exclusion in family and social affairs while young family members demean them by making cruel jokes on them and/or not being appreciated for making contributions in household chores [23]. Acts like failure to provide adequate food or medical care are included in this dimension [24]. Neglect by the caretaker should be differentiated from self-neglect [25] and Diogenes Syndrome (self-neglect associated with refusal of help) [26]. In a meta-analysis of geographically diverse studies that included 28 countries by Yon Y, psychological abuse was found to have highest prevalence estimates (11.6%) followed by financial abuse (6.8%), neglect (4.2%), physical (2.6%) and sexual abuse (0.9%) [27]. since most of the studies on EA have identified different elderly abuse types, a logical approach to start the classification of EA will be based on the types (Table 1).

Another class based on demographic characteristic of EA is outlined in table 1. Women (gender) have experienced more mistreatment than men (0.8% and 1.1% respectively) [28].

Among races, EA has been found to be more to blacks than whites [29]. Inconsistent EA and ethnicity association has been reported in a cohort study, although linking of cohort with the protective service records has been seen as reporting bias which resulted in overestimation of the ethnicity effect [30]. Evidence suggest that living alone puts the victim as potential risk for abuse thus suggesting the significance of family [31].

Table 1: Classifying Elder Abuse (EA).

A.	**According to type:** Physical, Mental, Psychological, Verbal, Financial, Emotional, Sociological, Sexual, Legal { legitimate and Illegitimate (abduction, killings) These can be active or passive}
B.	**According to demographics:** • Age subgroups: young old(60 to 69 years), the middle old (70 to 79), and the very old (80+) • Race: Black/white/brown skin or white/non-white [29] • Religious practice: Practicing/Non-practicing [82] • Gender: Male EA and Female EA [28] • Family size:Single parent family/ Nuclear family/ Extended family/Childless family/ Step family/ Grandparent family / Reconstituted family /living alone [23,32,37] • Ethnicity: Asian/Hispanic/American/ Indian [29] • Income: Very Low/Low/Normal/High/Very High [21,22] • Occupation/socioeconomic status: poor/working poor/working class/middle class/upper class/new money (recently rich class) [22,66] • Education: formal/non-formal/informal [63,65] • Dwelling: Rural and Urban [86]
C.	**According to characteristics** (like race, sex, caste , creed or religion): Discriminatory, Non-discriminatory
D.	**According to duration:** Continuous, Intermittent (regular or irregular) [55]
E.	**According to social occurrence:** 1. Individual level (Self neglect) [25] 2. Community level (isolation from home, accusations of witchcraft, mourning rites of widows, marriage with husbands brother)[24] 3. Community settings (rural and urban) [86] 4. Family level a) Institutional (panchayats, religious places like churches, mosques, temples gurudwaras, non-government run safe homes, old age homes, hospitals, jails) [83] b) Non institutional • At household level (family members, relatives, friends, neighbours, hired caregivers) [23] • At working level (boss, colleagues, clients, administration staff in institutions through imposing strict rules and regulations) [84]
F.	**According to care providers:** [19,49,64-67] • Formal caregivers (doctors, nurses, attendants, sweepers, servants, maids) • Informal caregivers (family members)
G.	**According to source:** direct, indirect
H.	**According to restrictions imposed**: Confined and free [62]
I.	**According to elder's need:** Existing needs, Created needs, Basic needs (withholding goods, medical care, responsibility, custody, services) [7,24,85]
J.	**According to the purpose of abuser:** Intentional (conscious, wilful, subconscious level), Unintentional (conscious and subconscious levels) [64,67]
K.	**According to intensity:** Harmful (threatening),Harmless (non-threatening) [67]
L.	**According to accepted laws and regulations**: Legitimate and Illegitimate [43,82]
M.	**According to apparentness:** Overt and Covert
N.	**According to abusers aggression:** Hostile and non-hostile, violent and non-violent [65]
O.	**According to risk factors of victim:** functional dependence/disability, poor physical and mental health, cognitive impairment, low income/socioeconomic status, race/ethnicity, gender [28,55,67,68]

Forums, policies and role of health care workers

Many developing nations of South East Asia like India, where value based and the joint family system still prevails have never focussed on EA as their social problem. With fast eroding traditional family system in the presence of rapid modernization, migration and urbanization, the subject of EA has undergone serious academic inquiry at the turn of the 21st century [32]. Countries like India have revealed a picture which is worthy of national concern [33-35]. Forums, policies and the role of healthcare professionals: EA for a long time was seen more as a social welfare issue and subsequently a problem of aging. But at present, given the projected demographic revolution that includes an increase in the number of living older adults throughout the world, EA emerges as a formidable social and health concern; and that the frequency of occurrences is likely to increase, proportionally as the population ages [36]. EA has also not developed into a public health and criminal justice concern [37]. Amongst various steps, International Network for the Prevention of the EA 2 has declared June 15th (first celebrated in 2005) as the "World EA Awareness Day" across the globe, to raise awareness about the vulnerability of the elder population to abuse and violence. Much before that in the year 2002, at Madrid (PAPD), governments were encouraged to develop and fund a National

comprehensive strategy and Agenda to prevent, detect and intervene in EA [38]. This declaration has led to the development of curriculum for nurses (IAFN), police (PERF), judges and court personnel, community corrections personnel and law enforcement officers [39], home care facilities [40], counselors [18] and medical health professionals [41,42]. In developing countries, some government and non-government organizations have optimistically made recommendations like formation of senior citizen forums, multi service community geriatric care center, EA helpline, counseling centers and laws to make EA a non-bailable offense [43].

Healthcare workers have significant implications in the identification, prevention and treatment of abuse in general. The trust and respect that patients often have for their health care providers places these professionals in a key position to help. Abuse is frequently denied, it becomes essential that assessment should be as holistic as possible. Besides, WHO [5,26] and AMA, [44] various authors [45,46] have also recommended the making of primary health workers aware of EA problem, as a crucial step in prevention and management. Besides incorporation of a short questionnaire related to EA in daily practice, identification of victims of violence, referral to proper authorities, training on interviewing techniques, risk assessment and safety planning, various procedures that link to resources need to be incorporated into undergraduate and continuing medical education programs [42]. Different tools available for diagnosis like HSEAST (Hwalek - Sengstock EA Screening Test) [47], BASE (Brief Abuse Screen for the Elderly) [48], IOA(Indicators of Abuse Screen) [48], CASE(Caregiver Abuse Screen) [49], EAI (Elder Assessment Instrument) [50,51] and EASI (EA Suspicion Index) [52] are reliable enough to diagnose EA and are not time consuming to diagnose existing EA patients [53]. A complete body examination, including genitalia revealing ulcers, bruises, lacerations or venereal diseases along with confirmatory laboratory tests such as radiographs [43], complete blood count, chemistries and serum albumin, [43] location, pattern, size cause and duration of injuries is a vital clue for suspicion of abuse [54,55]. Health care workers especially prosthodontist, due to long treatment time and procedures are in a better position to develop patient trust to elicit existing EA. This trust increases when dentists communicate with compassion and empathy [56]. Dentists may evaluate their patients on entry into the office by observing gait, appearance, communication skills and, of course, the head and neck region [57]. However, studies suggest that dentists and dental hygienists reported least education in abuse, least frequent rate of suspecting abuse and greatest proportion that did not see them as responsible for intervening into suspected abuse [58]. It has also been studied that predoctoral dental and medical students did not feel adequately trained to report a case of EA [59,60] despite abuse of children, elder, disabled and intimate partner being a part of their curriculum [61].

Dynamics and etiology of EA

EA is complex in nature as it develops over a period of time and involves neurological and behavioural psychology. Many theories have been forwarded to explain the mechanism of EA.

Situational theory: Claims that an overburdened and stressed caretaker creates an environment for abuse. The caretaker is an individual who as a result of family relationship is accountable for caring of elderly adult or who voluntarily or through contract has assumed this responsibility [62]. legally, it becomes critical to identify the circumstances under which a person has the duty to provide medical or hygiene care to an elderly or disabled adult who lives in a domestic setting [62]. Caring for elderly is cumbersome and physically and emotionally taxing to the caregiver [63,64]. Few people are prepared for the responsibilities and tasks involved in elder care, because of the stress involved. According to a study by Okoye in 2011, caregiver's sex and age, education level of both caregiver and care receiver were significantly related to the stress levels [63]. Dimensions of violence forms like violent feelings and violent behaviour in case of physical abuse is related to care giving demands, interactional stressors, caregiver characteristics and care giving context [65]. An important predictor of caregiver characteristic is his problems which range from behavioral, emotional, materialistic or familial [66]. Other factors which make a person prone to become abuser are level of depression in caregiver, quality of past relationship between caregiver and patient [67], alcohol and drug abuse and unemployment.

Feminist theory: Is founded on DMV (domestic model violence).The basis is power imbalance within relations and how violence is used as a mean to demonstrate power. The

characteristics of subjects who are prone to be abused are being a woman [68] (especially in male dominated society), isolation and missing social support network of the patient [66], past communication with the caregiver and emotional dependence on caregiver [67,68].

Exchange theory: Addresses reciprocity and dependence between the abused and the perpetrator. It implies that abuse occurs within a framework of tactics and responses in family life. The most pernicious predators are long term controlling relationships. In such cases, fear and helplessness are progressively bred by an individual (caregiver) with a sociopathic malignant narcissistic trait [69]. Psychologically the enforced helplessness, dependence, fear, undermining of self-esteem and unwillingness to effect change once the elder becomes trapped are similar to what occurs with hostages (Stockholm syndrome) [70].

Political economic theory: Criticizes the emphasis on individualistic theories, claiming that structural forces and the marginalization of elders within society have created conditions that lead to conflict and violence. Significant influence of social isolation and missing social support network on the occurrence of abusive behaviour has been found [66]. A correlation that is clinically significant between a mentally disturbed abuser and the abused is the basis for Intra-individual dynamics (psychopathology) theory.

Intergenerational transmission or social learning theory: States such adult behaviour as learned one during childhood, the pattern of which he reverts when he becomes an adult. The diversity of theoretical models shows the complexity of such behaviour. The ecological model is an example of a broader approach to the topic of EA based on the social ecological theory of Hawley. On one side, it claims that individual characteristics like personal history and interpersonal relationships play a role why someone tends towards abusive behaviour. On other side, it stresses the relevance of characteristics of the community the person lives in and existing social norms and policies [24,71].

Management

Abuse is usually multifactorial and of different types. The first objective should be to determine the type of abuse and the potential abuser. Multidisciplinary approach that involves relevant health and social care members to form a team that is personalized to meet the elderly individual needs is essential. Any management plan should be patient-centered and respectful of their autonomy, confidentiality and dignity. Strategies should include exceptional cases like an adult with schizophrenia who is abusing his or her parent requires a quite different support strategy than to a person suffering from dementia and consciously beating his spouse. Sexual or physical abuse, theft or fraud need police reporting since they are criminal offences. Intervention of a health care worker in EA in some places in USA is legislatively mandated, and it is the responsibility and legal obligation for health care worker to report suspected cases [72]. Proper training of health care workers in dealing with issues like abuse remains a major barrier to patient screening and reporting [72,73]. Dentist as a counseling psychologist should learn the art form of combining and integrating these skills in a coherent manner [74]. The overall goal of intervention is to benefit the abused elder. Ideally, the appropriate time to intervene is before episode happens [75]. Possible interventions include intensive family counseling at the time an aging parent moves into the adult child's home, specific training in the care of dependent older persons, and consuming community support services. Such community services include day care, financial aid, "meals on wheels," home nursing services, elder "sitters," accessible transportation [4,11,62,76,77], and nurse educators [78]. All these services could allow "time off' for the adult caretaker, relieving some of the stresses of caring for an aging parent. The intent is to assist the adult caretaker to cope with the role and to prevent the occurrence of situations that might lead to abuse [76]. Counseling is an important aide to prevent EA. Counseling demands one to first identify the reasons of particular abuse. Counseling of the abuser and the abused should be directed towards eliminating the cause as well finding other solutions of care giving. The purpose of counseling an adult client with depression should facilitate self-understanding, self-communication and counselor communication [79]. Counselors can assist families by providing accurate information and resources for learning about aging (example self- help books). Aging parents need to be understood using resources [80]. Techniques for enhancing positive interaction and dealing with stress may be taught by counselors in support group settings and in individual counseling. Assertive training

for both older persons and their caregivers has been found to be helpful [80]. The problems of counseling include identifying potentially abusive situations. Physical evidence of maltreatment is non-evident at times, and families hide information for fear of the consequences, lack of comfort, fear of offending, powerlessness, loss of control, time constraints [81] and more importantly laws pertaining to the reporting of EA in particular jurisdiction [82]. The role of the support network for individual older persons will help to provide relief and respite for family members responsible for their care. Similarly, expansion of the support networks for family members will provide needed relief valves for tension and stress. In India, evidence suggests that although basic needs of institutionalized elders are met at old age homes, the psychological, emotional and financial needs are however not adequately met. Providing emotional support along with arranging social and income generation activities for elders are needed [83,84]. EA in any of its forms can lead to serious complications. The mortality associated with EA has been studied and it has been found that EA victims have poorer survival rate than those of self-neglect [84] Forensic aspects of EA have been studied in the literature [85] and have been pointed that deliberate withholding of medical care and other basic necessities can lead to an elderly death.

Significance of classification

The discussion of demographics, role of health care professionals, Aerodynamics and management of EA is the foundation for understanding the significance of a classification system (Table 1). These parameters are multifaceted, complex, interdependent and dynamic which makes clinical understanding of EA difficult. Presently, the individual characteristic types of EA are vaguely defined since overlapping of features exists. Classifying a type under a parameter will allow different types with common characteristic to be easily diagnosed and managed. However, this classification should be just a beginning and should be subjected to further refinement and research [86].

CONCLUSION

EA existence in society is factual, and ignorance of such issue cannot be denied due to social, cultural and religious restrictions. Since it is a complex behavioural issue (psychology of relations) which has a broad clinical picture a outlined classification is a simple step in understanding of this social issue. The classification is open to criticism and needs further refinement through scientific research.

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REFERENCES

1. (2002). Active ageing: a policy framework. Geneva, World Health Organization.
2. (2010). Department of Justice Observes June 15 as World Elder Abuse Awareness Day.
3. (2005). World population prospects: the 2004 revision highlights. New York, United Nations.
4. Randal J, German T, Ewing D. (1999). The ageing and development report: poverty, independence, and the world's people. London; Help Age International.
5. Gorbein ML, Eisentein AR. (2005). Elder Abuse and neglect: An overview. Clin Geriatr Med. 21: 279-292.
6. Burston GR. (1975). Granny battering. Br Med J. 3: 592.
7. Elder abuse and neglect. Council on Scientific Affairs. (1987). JAMA. 257:966-971.
8. US House of Representatives HR1674: The Elder Abuse Prevention, Identification, and Treatment Act. (1985).
9. Johnson T. (1986). Critical issues in the definition of elder mistreatment, in Pillemer KA and Wolf RS (Ed 5): EA: conflict in the family. Dover MA, Aubum House Publishing Co, 1986:167-96.
10. Fulmer TT, O'Malley TA. (1987). Inadequate care of the elderly. New York Springer Publishing Co.
11. Hudson MF. (1989). Analysis of the concept of elder mistreatment: Abuse and neglect. Journal of ElderAbuse & Neglect. 1: 5-26.
12. Johns S, Hydle I, Aschjem O. (1991). The Act of Abuse: a two headed monster of injury and offence. J. Elder Abuse and Neglect. 3: 53-64.

13. Bonnie R, Wallac R, eds. (2003). Elder mistreatment: abuse, neglect and exploitation in an aging America. Washington DC: National Academies Press.
14. Lowenstein A, Eisikovits Z, Band-Winterstein T, Enosh G. (2009). Is Elder Abuse and neglect a social phenomenon? Data from the First National Prevalence Survey in Israel. J Elder Abuse Negl. 21: 253-277.
15. Jeong, SI, Park MR. (2016). A study on the classification of elder abuse types. Industry Promotion Research. 1: 91-103.
16. World Medical Association. (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. JAMA. 310: 2191-2194.
17. Pillemer K, Finkelhor D. (1988). The prevalence of Elder Abuse: A random sample survey. Gerodontologist. 28: 51-57.
18. Welfel ER, Danzinger PR, Santoro S. (2000). Mandated reporting of abuse/maltreatment of older adults: A primer for counselors. Journal of counseling and development. 78: 248-292.
19. Ho CS, Wong SY, Chiu MM, Ho RC. (2017). Global Prevalence of Elder Abuse: A Meta-analysis and Meta-regression. East Asian Arch Psychiatr. 27: 43-55.
20. Senn DR, McDowell JD, Alder ME. (2001). Dentistry's role in the recognition and reporting of domestic violence, abuse and neglect. Dent Clin North Am. 45: 343-363.
21. Wilber KH, Reynolds SL. (1997). Introducing a framework for finding financial abuse of the elderly. J Elder Abuse Neglect. 8: 61-86.
22. Savill R. (2009). Couple tricked farmer of 1 m £ property. The Telegraph.
23. Shah G, Veedon R, Vasi S. (1995). Elderly abuse in India. J Elder Abuse Negl. 4:18-19. Book
24. Perel - Levin S. (2008). Discussing screening for Elder Abuse at Primary health care level. WHO.
25. Dyer CB, Goodwin JS, Pickens-Pace S, Burnett J, Kelly PA. (2007). Self-neglect among the elderly: A model based on more than 500 patients seen by a geriatric medicine team. Am J Public Health. 97:1671-1676.
26. Ahmad M, Lachs MS. (2002). Elder Abuse and neglect: what physicians can and should do. Cleve Clin J Med. 69:801-808.
27. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. (2017). Elder Abuse prevalence in community settings: a systematic review and meta-analysis. Lancet Glob Health. 5: 147-156.
28. O'Keeffe M, Hills A, Doyle M, McCreadie C, Scholes S, et al. (2007). UK study of abuse and neglect of older people: Prevalence survey report. National Centre for Social Research. 19: 1-182.
29. Amendola KL, Meghan GS, Edwin EH, Julie LW. (2010). The course of domestic abuse among Chicago's elderly: Risk factors, protective behaviours and police intervention. Police Foundation Report.
30. Lachs MS, Williams C, O'Brien S, Hurst L, Horwitz R. (1997). Risk factors for reported Elder Abuse and neglect: a nine-year observational cohort study. Gerontologist. 37: 469-474.
31. Li Wu, Hui Chen, Yang Hu, Huiyun Xiang, Xiang Yu, et al. (2012). Prevalence and associated factors of elder mistreatment in a rural community in People's Republic of China: a cross-sectional study. PLoS One. 7: 33857.
32. Shankardass MK. Combating Elder Abuse in India: An emerging social, legal and public health concern, symposists' papers, invited symposia on Elder Abuse, executive editor, Toshio Tatara, Tokyo International Forum, Japan.
33. Verma SK. (2009). Subjective experiences of abuse and neglect among eastern U.P. elderly: A qualitative approach. Indian J Social Science Researches. 6: 84-91.
34. Times of India, Banglore. Bangalore tops Elder Abuse cases: Survey. 2011.
35. Bambawale U. (2006). Abuse of elderly: A myth or reality. Handbook of Indian Gerontology. Serial Publication.
36. Wieland D. (2000). Abuse of older person: an overview. Holist nurs pract. 14: 40-50.
37. Abuse of the elderly. World report on violence and health. chapter 5: 125-145.
38. (2002). Second World Assembly on Ageing, Plan of Action and Political Declaration. Madrid, Spain.
39. Connally MT. (2008). Elder self-neglect and the justice system: An essay from an interdisciplinary perspective. J Am Geriatr Soc. 56: 244-252.

40. National Assistance Act 1948 – ss47 - 48 and National Assistance (Amendment) Act 1951 - s1.
41. Violence against women. Relevance for medical practitioners. Council on Scientific Affairs, American Medical Association. (1992). JAMA. 267: 3184-3189.
42. Caciula I, Livingston G, Caciula R, Cooper C.. (2010). Recognition of Elder Abuse by home care workers and older people in Romania. Int Psychogeriatr. 22: 403-408.
43. Levine JM. (2003). Elder neglect and abuse: A primer for primary care physicians. Geriatrics. 58: 37-44.
44. Elder Abuse. Socrates Programme "Focus on Ethics and Quality in Dementia Care" University of Cadiz [internet] Available from: http://www2.uca.es/dept/enfermeria/socrates/demencia/martina
45. Aravanis SC, Adelman RD, Breckman R, Fulmer TT, Holder E, et al. (1993). Diagnostic and treatment guidelines on Elder Abuse and neglect. Arch Fam Med. 2: 371-388.
46. Rosenblatt DE. (1996). Elder Abuse: what can physicians do? Arch Fam Med. 5: 88-90.
47. Hwalek MA, Sengstock MC. (1986). Assessing the probability of abuse of elderly: Towards the development of clinical screening instrument. J Appl Gerontol. 5: 153-173.
48. Reis M, Nahmiash D. (1998). Validation of the indicators of abuse (IOA) screen. Gerontologist. 38: 471-480.
49. Reis M, Nahmiash D. (1995). Validation of the Caregiver Abuse Screen (CASE). Canadian Journal on Aging. 14: 45-60.
50. Fulmer T, Paveza G, Abraham I, Fairchild S. (2000). Elder neglect assessment in the emergency department. J Emerg Nurs. 26: 436-443.
51. Fulmer T. (2008). Screening mistreatment of older adults: The elder assessment instrument can alert nurses to signs of abuse, neglect and exploitation. AJN. 108: 52-59.
52. Yaffe M et al. (2004). Development and validation of a suspicion index for Elder Abuse for physicians' use: results and implications. Invited presentation to the Ageing and Life Course unit of World Health Organization, Geneva. Montreal McGill University.
53. Mattoo KA, Shalabh Kumar, A Khan. (2009). Prevalence of Elder Abuse among completely edentulous patients seeking complete denture prosthesis: A survey. J Indian Academy Geriatrics. 5: 177-1780.
54. Mosqueda L, Burnight K, Liao S. (2005). The life cycle of bruises in older adults. J Am Geriatr Soc. 53: 1339-1343.
55. Wiglesworth A, Austin R, Corona M, Schneider D, Liao S, et al. (2009). Bruising as a marker of physical Elder Abuse. J Am Geriatr Soc. 57: 1191-1196.
56. Epstein RM. (2003). Virtual physicians, health systems, and the healing relationship. J Gen Intern Med. 18: 404-406.
57. Ochs HA, Neuenschwander MC, Dodson TB. (1996). Are head, neck and facial injuries markers of domestic violence? J Am Dent Assoc. 127:757-761.
58. Wiseman M. (2008). The Role of the Dentist in Recognizing Elder Abuse. J Cand Dent Ass. 74: 715-720.
59. Thompson-McCormick J, Jones L, Cooper C, Livingston G. (2009). Medical students' recognition of Elder Abuse. Int J Geriatr Psychiatry. 24: 770–777.
60. Gironda MW, Lefever KH, Anderson EA. (2010). Dental Students' Knowledge about Elder Abuse and Neglect and the Reporting Responsibilities of Dentists. J Dent Educ. 74: 824-829.
61. Gutmann ME, Solomon SE. (2002). Family violence content in dental hygiene curricula: A national survey. J Dent Educ. 66: 999-1005.
62. Saxon JL. (1996). Prosecuting the abuse, neglect, and exploitation of elderly and disabled adults in North Carolina. Elder law. 3: 1-22.
63. Okoye UO, Asa SS. (2011). Caregiving and Stress: Experience of People Taking Care of Elderly Relations in South-eastern Nigeria. Arts and Social Sciences Journal. 29: 1-9.
64. Senanarong V, Jamjumras P, Harmphadungkit K, Klubwongs M, Udomphanthurak S, et al. (2004). A counseling intervention for caregivers: effect on neuropsychiatric symptom. Int J Geriatr Psychiatry. 19: 781-788.
65. Pillemer K, Suitor JJ. (1992). Violence and violent feelings: what causes them among family caregivers? J Gerontol. 47: 165-172.
66. Cohen M, Halevi-Levin S, Gagin R, Friedman G. (2006). Development of a screening tool for identifying elderly

people at risk of abuse by their caregivers. J Aging Health. 18: 660-685.

67. Williamson GM, Shaffer DR. (2001). Relationship quality and potentially harmful behaviors by spousal caregivers: How we were then. How we are now. The Family Relationships in Late Life Project. Psychol Aging. 16: 217-226.
68. Shankardass MK. (2009). India: Elder Abuse - Vulnerability of Ageing Women.
69. Jamuna D. (2003). Issues of elder care and Elder Abuse in the Indian context. J Aging Soc Policy. 15: 125-142.
70. Ryan CW, Richard CW, Marcia JC. (2005). Exploitation of the elderly: undue influence as a form of Elder Abuse. Clinical Geriatrics. 13: 28-36.
71. Hardin E, Schlater TL. (1987). Dynamics of parental abuse. J Nat Med Ass. 79: 674-676.
72. Aved BM, Meyers L, Burmas EL. (2007). Challenging Dentistry to Recognize and Respond to Family Violence. J Calif Dent Assoc. 35: 555-563.
73. Tilden VP, Schmidt TA, Limandri BJ, Chiodo GT, Garland MJ, et al. (1994). Factors that influence clinician's assessment and management of family violence. Am J Public Health. 84: 628-633.
74. Blair L. (2010). A critical review of the scientist practitioner model for counseling psychology. Counseling Psychology Review. 25:19-31.
75. Dutta D. (2006). Geriatric Assessment, Counseling and Psychotherapy. [internet]. Available from: http://www.isical.ac.in/~ddroy
76. Elder Abuse – questions and answers. Developed by Elder Abuse Intervention team (EAIT) 2007 June 11.
77. Hardin E, Khan-Hudson A. (2005). Elder Abuse - "Society's Dilemma". J Natl Med Assoc. 97: 91-94.
78. Bastable BS. (2007). Literacy in the Adult Client Population. Jones and Bartlett publisher. Ch. 7: 1- 56.
79. Lee KL, Mustaffa MS. (2011). Using art in counselling adults: A pilot study. Asia Pacific Journal of Counselling and Psychotherapy. 2: 98-114.
80. Myers JE, Shelton B. (1987). Abuse and older persons: Issues and implications for counselors. Journal of counseling and development. 65: 376-380.
81. Sugg NK, Inui T. (1992). Primary care physician's response to domestic violence: opening Pandora's Box. JAMA. 267: 3157-3160.
82. Rudnick JD. Catalyzing Elder Abuse and Neglect Prevention and Intervention: The Case for Counselor-Clergy Collaboration. Journal of Trauma Counseling International.
83. Prabhavathy DN, Tamilarasi PM. (2006). Institutional Care for the Elderly. Journal of the Indian Academy of Geriatrics. 2: 15-20.
84. Sun AP. (2012). Helping Homeless Individuals with Co-occurring Disorders: The Four Components. Soc work. 57: 23-37.
85. Mattoo KA, Shalabh K, Khan A. (2010). Geriatric forensics: A dentist's perspective and contribution to identify existence of EA among his patients. J Forensic Dent Sci. 2: 81-85.
86. Chokkanathan S, Lee AEY. (2005). Elder mistreatment in urban India: A community based study. J Elder Abuse Negl. 17: 45-61.