Protection Through Connection: Social Support as a Key Intervention & Prevention Component in Elder Abuse

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Goal of the Talk:

Use a theoretical Model of Social Support and research from a variety of areas to Investigate the role of

**Social Connection in terms of:**

- *Protection* before elder abuse happens to older adults, and
- *Resiliency* after elder abuse happens
Social Support and Health

Perceived social support is one of the most well-documented *psychosocial* factors influencing physical health outcomes (Berkman et al., 2000; Cohen, 1988; Holt-Lunstad et al., 2010; House et al., 1988; Pinquart & Duberstein, 2010; Uchino, 2004).

Epidemiological studies indicate that individuals with low levels of social support have higher mortality rates; especially from cardiovascular disease (Barth, Schneider, & von Kanel, 2010; Berkman, Leo-Summers, & Horwitz, 1992; Orth-Gomér, Rosengren, & Wilhelmsen, 1993).

Although more research is needed, there is also evidence linking support to lower cancer and infectious disease mortality (Ell, Nishimoto, Medianski, Mantell, & Hamovitch, 1992; Lee & Rotheram-Borus, 2001; Pinquart & Duberstein, 2010).

In perhaps the most compelling evidence to date on the health effects of social support, a meta-analysis of the existing literature found that perceived support was related to significantly lower risk for all-cause mortality (Holt-Lunstad et al., 2010).

Indeed effect sizes from this meta-analysis appeared as large, if not larger, than standard medical factors such as exercise and obesity.
Social Support & Health: 2 Theoretical Models that indicate where research foci should be

MODEL #1: **Main Effect/Direct/Positive Affect Model:**
- Social support improves health and mental health, irrespective of environmental stressors

MODEL #2: **Buffering (Interaction) Model:**
- Social Support mitigates the negative effects of environmental stressors...in other words, more important when faced with stressors.
Main Effect/Direct Model of Social Support & Mental Health/Health

- In the simplest explanation of this model, social support leads to positive affect, which improves mental health.
- Social support also (hopefully) leads to positive health behaviors, which lead to improved health & mental health.
- Social support has positive biologic effects, which leads to better health.
- The first two have been extraordinarily well supported by research, are simple explanations, and thus seem to justify social support as an intervention for mental health among those experiencing stress.
Model 2 The buffering effects model: Social Support and Health/Mental Health

Stress introduced to the system

Perceived Availability of Social Resources

Perceived Stress

Appraisal of Demands and Adaptive Capacities

Benign Appraisal

Buffered Negative Cognitive & Emotional Response

Physiological or Behavioral Response

Health + Mental Health

Not yet consistently supported by research

Buffering Model of Social Support & Mental Health/Health

• Mechanisms postulated by this model (i.e., how does social support translate into improved health/mental health following trauma) suggest that “direct effects” of social support on health may be mediated by positive affect, predictability, predicted assistance and a sense of self-worth (also see Cohen, 1988).

• In this view, the belief that others will provide necessary resources may bolster one’s perceived ability to cope with demands, thus changing the appraisal of the situation and lowering its effective stress.

• Belief that support is at hand (i.e. “the cavalry is coming”) may also dampen the emotional and physiological responses to the event or alter maladaptive behavioral responses. (Cohen, 2004)
Does it matter which model is correct in terms of (a) how our research should be directed and (b) how we should intervene?

- **Yes**, insofar as the **type & timing** of social support becomes more important in one model with respect to context, and thus must be differentially assessed in research efforts.

- **No**, insofar as both types of social support are likely when **social connection** (that is, the **OPPORTUNITY** for social support) is facilitated.

- **OVERALL**, If either Model is correct, effects of elder abuse (or other stress events) should be mitigated by **SOCIAL CONNECTION**: a testable hypothesis.
So let’s look at some of our studies on stress events and older adults, considering social support.
Psychological Sequelae Resulting From the 2004 Florida Hurricanes: Implications for Postdisaster Intervention

Ron Acerno, PhD, Kenneth J. Ruggiero, PhD, Sandro Galea, MD, MPH, Heidi S. Resnick, PhD, Karestan Koenen, PhD, John Ritzlach, PhD, Michael de Arellano, PhD, John Boyle, PhD, and Dean G. Kilpatrick, PhD

The 2004 hurricane season brought Florida an unprecedented 4 hurricanes (named Charley, Frances, Ivan, and Jeanne) over a 7-week period between August 13 and September 25, 2004. These hurricanes inflicted tremendous damage, including an estimated 12,4 deaths and US$40 billion in costs to insured property. Three of these storms were classified as major hurricanes at landfall (i.e., maximum sustained wind speed >110 mph), the greatest number of major hurricanes ever recorded for Florida in a single season.

To date, the best estimates of the health-related impact of the 2004 hurricane season come from a Centers for Disease Control and Prevention report. That report summarized data from a random-digit dial telephone interview conducted between November and December 2004 with a sample of 1,018 participants representing all 67 counties in Florida. Although results from this survey should be interpreted cautiously in light of the low (43%) response rate, major findings included the following: (1) the quality of drinking water, sewage disposal, and food protection were cited as moderate to high among environmental concerns associated with hurricanes; (2) nearly 20% reported at least “moderate” damage to their residence (i.e., US$500 in damage); (3) 8% reported “severe” or “catastrophic” damage; (3) 4% experienced physical injuries; (4) nearly half of respondents employed at the time of the hurricanes missed work or lost their jobs, and 39% missed work for at least 5 days; and (5) among persons with medical conditions, 5% noted a worsening of their condition, 14% reported difficulties obtaining medication, and 9% reported barriers to accessing essential medical equipment. Notably, many of these consequences were approximately as prevalent in counties that were versus those that were not in the direct path of the hurricanes. This assessment also found that 11% of participants reported anxiety, nervousness, or worry; 6% reported sadness, loss of appetite, or difficulty sleeping; and 4% reported reduced mental capacity to study or work.

Findings from the Centers for Disease Control and Prevention report provide some insight into the degree of physical threat, loss, bereavement, and social and community disruption experienced by Florida residents in the short-term aftermath of the 2004 hurricanes. Little is known, however, about the mental health impact of these hurricanes and associated risk factors. Previous research demonstrated that emotional effects of natural and manmade disasters can be quite significant and that negative postdisaster mental health outcomes are associated with long-term problems in health, recovery, and economic burden. Although recent epidemiological data indicate general population 12-month prevalences of 3.5% for posttraumatic stress disorder (PTSD), 6.7% for depression, and 3.1% for generalized anxiety disorder, postdisaster 12-month prevalences for these disasters are likely higher. For example, Kessler et al. found 12-month prevalences of PTSD secondary to natural disasters to be 11.3%; however, this finding was only with respect to disasters involving fire, and no disaster-specific prevalences were offered for depression or other anxiety disorders.

A second general population study of natural disaster victims observed elevations in 6 of 10 symptom scales measuring anxiety and depression but did not specifically assess PTSD, depression, or generalized anxiety disorder at the diagnostic level and did not disaggregate findings in terms of hurricane exposure. Surprisingly little information is available from epidemiologically-based studies on the prevalence of PTSD, depression, and anxiety in adults after hurricanes. However, both published and unpublished data from hurricane and other natural disaster survivors indicate that peristorm and poststorm exposure variables that include displacement and resource loss (e.g., property damage) play a role in determining mental health outcomes.

We sought to determine the prevalence of PTSD, generalized anxiety disorder, and major depressive episode among Florida residents living in counties directly affected by the 2004 hurricanes and to identify risk and protective factors associated with these disorders. We focused on PTSD, generalized anxiety disorder, and major depressive episode, because these disorders are among the most common in the aftermath of disasters and traumatic events.
Florida Hurricanes Study: Sample Characteristics

- 1,130 older adult participants,
- 64.5% female and 35.5% male; 4.3% Hispanic
- mean age was 71.0 years ($SD = 7.9$)

Let’s take a look at mental health in those with low social support:
Prevalence of Emotional Problems in Terms of Low Social Support

- PTSD-G: 7.3%
- PTSD-H: 2.5%
- Depression: 13.2%
- GAD: 9.9%
But now let’s look at the same group with high social support
Prevalence of Emotional Problems in Terms of Low and High Social Support

<table>
<thead>
<tr>
<th>Condition</th>
<th>High Support</th>
<th>Low Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD-G</td>
<td>7.3%</td>
<td>1.7%</td>
</tr>
<tr>
<td>PTSD-H</td>
<td>0.3%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>2.1%</td>
<td>13.2%</td>
</tr>
<tr>
<td>GAD</td>
<td>3.2%</td>
<td>9.9%</td>
</tr>
</tbody>
</table>
**Conclusion**

- 10% evinced mental health problems following the disaster.

- **High Social Support** prior to the disaster (Buffering Model of Social Support) reduced risk of ALL forms of mental illness post disaster.

- Fancy psychological treatments are not what is needed.....**social support is key**
Treatment of Complicated Bereavement by increasing social connection
Treatment of Bereavement Using Exposure and Behavioral Activation

Specific Intervention components

- Behavioral activation planning forms....plan for values-based social interactions and resolve scheduling barriers ahead of time

- Note this increased social support after the stress event....(Main Effect Model of Social Support)

- A Simple GOAL: Increase social interaction and connection
RESULTS:
*Complicated Grief Assessment
*Beck Depression Inventory

Effect Size: CGA = .68; BDI = .62
How about: Combat Veterans
Combat Veterans Response to Treatment
High Vs Low Social Support

PTSD Clinical Scale (lower is better)
A few more examples for good measure from the work of others:

Dementia
Parkinson’s
Social activity is critical for motor functioning.
Buchman, Boyle, ... Bennett 2010
Combat, Disaster, Medical Illness, and .......

Elder Abuse
The National Elder Mistreatment Study

- **5,777 COMMUNITY RESIDING** adults age 60 UP
- **60.2% female, 39.8% male**
- **Average age 71.5 years (SD = 8.1)**
- **85% White, 7% Black, 4.3% Hispanic**


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The National Elder Abuse Incidence Study, conducted more than a decade ago, was the first major investigation of mistreatment of the elderly in the United States. It found that 449,524 persons aged 60 years or older had been physically abused, neglected, or in some way mistreated in 1990. However, the study did not solicit data directly from older adults; rather, it assessed Adult Protective Service records and sentinel (e.g., community professionals) reports. Thus, it is very likely that the results greatly underestimated the true scope of the problem of abuse of older Americans, because a large majority of cases are unreported and are undetected by monitoring agencies.

In another, earlier investigation, more than 2,000 older adults in the Boston area were directly questioned about their experiences. Extraposed data indicated that approximately 100,000 US adults had experienced abuse since reaching age 60 years, with 2% reporting physical abuse and 1% verbal abuse. Only approximately 1 in 14 cases was reported to authorities. Other investigators have conducted preliminary assessments of abuse prevalence among the elderly, but most were completed 2 to 3 decades ago. A telephone survey of 2,000 randomly selected elderly Canadians found that 0.5% suffered physical abuse and 1.4% emotional abuse since they reached age 60 years. In a random sample of older adults in New Jersey, researchers found an abuse rate of approximately 1%. In a sample of elderly persons in Maryland, the rate was 4.1%. A study of respite care workers in Great Britain found that 45% admitted committing either verbal (41%) or physical (4%) abuse since they began working with the elderly. Interestingly, frequency of patient reports of abuse was less than that of caregivers. Finally, a record review of 404 patients in a chronic illness center identified abuse symptoms in 94% of participants.

Most recently, Laumann et al. appended mistreatment questions to the National Social Life, Health, and Aging Project, a study of a nationally representative sample of older Americans. The survey asked 3,005 individuals aged 57 to 85 years about past-year physical, verbal, and financial abuse. Two thirds were interviewed in person, and the remainder completed a booklet of questions that was left for participants to read and answer independently (i.e., with no interviewer present). Past-year prevalence was 9.0% for verbal, 0.2% for physical, and 3.5% for financial mistreatment. Respondents toward the younger end of this age range were more likely to experience verbal and financial mistreatment. Women and physically frail elderly persons were more likely to experience verbal mistreatment. African Americans and those in poor health were more likely to report financial exploitation, and Latinos were less likely than respondents from other ethnic groups to report either form of victimization.

This study, although it improved on previous investigations of the problem, had significant limitations. It did not query about some forms of abuse (e.g., sexual assault and neglect were not studied). Moreover, each type of abuse was assessed with only 1 short question. The literature on the epidemiology of interpersonal violence against younger and middle-aged adults demonstrates that to identify abuse and assault events adequately, assessments need to use comprehensive, behaviorally defined descriptions of interpersonal violence events in closed-ended questions.

To build on existing research and address the limitations of previous studies, we designed a study of mistreatment among the elderly in the United States with the methods, definitions, and inclusion of potential correlates (e.g., demographic factors and dependency variables such as use of social services, need of assistance with activities of daily living, health status, and social support) outlined by the National...
Past Year Emotional Abuse

- Overall: 4.6%
- Verbal: 3.2%
- Humiliation: 2.2%
- Harrassment: 2.2%
- Ignored: 4.0%
Significant Risk factors & Odds Ratios (OR) for Emotional Mistreatment

- Lower Age (OR = 3.2)
- Being Employed (OR = 1.8)
- Poor Self-Rated Health (ns)
- Prior Traumatic Event (OR = 2.3)
- Needing ADL Assistance (OR = 1.8)

- Low Social Support (OR = 3.2)
Let's take a look at that Social Support risk factor
Rate of **Emotional Abuse** in terms of **Social Support**

Social Support High Vs Low

- **High Soc Support**
  - 2.6%

- **Low Soc Support**
  - 7.9%
Past Year Physical Abuse

- Overall: 1.6%
- Hit: 1.2%
- Restrained: 0.4%
- Injured: 0.7%
Significant Risk factors for Physical Mistreatment

- Lower Age (OR = 4.1)
- Non-White Racial Status
- Lower Income
- Poor Self-Rated Health
- Prior Traumatic Event

- Low Social Support (OR = 3.0)
And now Let's take a look at that Social Support risk factor again
Rate of **Emotional** and **Physical** Abuse in terms of **Social Support**

<table>
<thead>
<tr>
<th>Social Support High Vs Low</th>
<th>High Soc Support</th>
<th>Low Soc Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Abuse</td>
<td>2.6%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>1.0%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
Past Year Sexual Abuse

Overall: 0.6%
Forced Sex: 0.4%
Molestation: 0.2%
Forced Undress: 0.1%
Photo Nude: 0.1%
...one more time....
Let's take a look at that Social Support Risk Factor
Sexual Mistreatment: Significant Risk factors

- Female Gender
- Low Income
- Poor Self-Rated Health
- Prior Traumatic Event
- Needs ADL Assistance

- Low Social Support
Rates of Emotional, Physical, and Sexual Abuse in terms of Social Support

Social Support High Vs Low

- Emotional Abuse: 2.6% High Soc Support, 7.9% Low Soc Support
- Physical Abuse: 1.0% High Soc Support, 2.5% Low Soc Support
- Sexual Abuse: 2.6% High Soc Support, 7.9% Low Soc Support
Summary: Risk Factors Across Mistreatment:

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>EMOTIONAL</th>
<th>PHYSICAL</th>
<th>SEXUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Age</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Non-White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being Employed</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Self-Rated Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Traumatic Event</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low Social Support</strong></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Use Social Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needing ADL Assistance</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
One more time....
Rates of Emotional, Physical, and Sexual Abuse in terms of Social Support

Social Support High Vs Low

- **Emotional Abuse**
  - High Soc Support: 7.9%
  - Low Soc Support: 2.6%

- **Physical Abuse**
  - High Soc Support: 1.0%
  - Low Soc Support: 2.5%

- **Sexual Abuse**
  - High Soc Support: 7.9%
  - Low Soc Support: 2.6%
So, that was `how often' abuse happens. And how Social Support can reduce the risk of even being abused.

How about `so what,' as in: what are the effects of abuse and what can make it better or worse.
The National Elder Mistreatment Study 8 Years Later: A study on potential effects of abuse
8 Years Later: Effects of Elder Abuse in Terms of Health, Anxiety (PTSD), & Depression

- BadHealth (OR 4.6)  
  - No Abuse: 46.0%  
  - Abuse: 79.0%

- Anxiety (OR 6.7)  
  - No Abuse: 2.9%  
  - Abuse: 16.7%

- Depress (OR 3.3)  
  - No Abuse: 13.0%  
  - Abuse: 34.0%
But now let’s see what happens if we consider high *social support*, as rated by the older adult back then, 8 years ago when the abuse happened (Buffering Model)
8 Years Later: Social Support’s impact on Effects of Elder Abuse in terms of Health (Lowest quartile), Anxiety (PTSD), & Depression

- Poor Health (OR 4.6): 79.0% Abuse, 46.0% No Abuse
- Anxiety (OR 6.7): 2.9% Abuse, 16.7% No Abuse
- Depression (OR 3.3): 13.0% Abuse, 34.0% No Abuse
8 Years Later: Social Support’s impact on Effects of Elder Abuse in terms of Health (Lowest quartile), Anxiety (PTSD), & Depression

Social Support Eliminates negative effect of abuse

- Poor Health (OR 4.6)
- Anxiety (OR 6.7)
- Depression (OR 3.3)
Summary: Considering Elder Abuse

1 in 10 community-residing older adults reported experiencing elder mistreatment in the past year.

But...Social support is a central protective factor, preventing virtually all forms of elder mistreatment.

And...Followup research 8 years later shows social support protects you after you’ve been abused from developing problems with health, anxiety, and depression.
So...which theoretical model of social support enhancing mental health is right?

- Of course, the short answer is both: having social support makes you happier, and having social support makes it easier to deal with stress.

- But on the whole, our research across populations seems to indicate that the buffering hypothesis is critical insofar as the relevance of support to outcomes really becomes apparent in the context of a stressor event.
Conclusions: **Bad stuff happens**

- If you consider mistreatment, disasters, war and loss, bad stuff happens to older adults. A lot.

  BUT MAYBE ITS NOT SO BAD.....

- Older Adults deal with these events relatively better than younger adults
- There are certain things we can do to improve chances that things will be ok:

  - **Social Support is foremost among these, either before the abuse through social connection, or following the abuse through being good neighbors**
This social support thing seems to be important

what kind of tea is that??
i don't know. i found it at my grandson's room!
LOW Social Support is related to everything bad that can happen.....and that means it is related to everything GOOD that can happen

- This is a GOOD finding because Social Support is a Modifiable Construct

- Activities of a social nature might be helpful to prevent abuse, promote resilience, and improve quality of life, particularly after traumatic stressors.
These findings suggest using an atypical approach to addressing elder abuse: Increasing Social Support by meeting patients where they’re at

- Perhaps starting health and wellness groups in community settings that include assessment of mental health and abuse, alongside blood pressure and weight, with subsequent opportunities for discussion of these issues.

- Things like redesigned meeting places (benches, tables, public café permits) or easy public Transportation are very likely the most effective, useful, and efficient mental health and socialization elder abuse interventions for older adults.

- The “evening walk” in the community has to return
We need to make it easier for older adults to connect.....
Social Support Can come in Many Forms