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Psycho-Educational Support Groups for Older Women Victims of Family Mistreatment: A Pilot Study

Patricia Brownell, PhD
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SUMMARY. Few programs for domestic violence victims have been evaluated for effectiveness. This gap is even more pronounced for elder abuse service interventions. The study presented here is intended to address this gap by using an experimental research design to evaluate outcomes of an elder mistreatment psycho-social support group pilot for cognitively unimpaired older female victims of mistreatment by family members and significant others for whom they are providing care or support. The support group model used for the study adapts a model designed by NOVA House, an elder abuse shelter program in Manitoba, Canada. The study was funded by the Hartford Foundation Geriatric Social Work Faculty Scholars Program. While the significance of study findings is limited by the small number of pilot participants, the model intervention and evaluation instrument developed for the study may be utilized for study replication. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]*

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KEYWORDS. Elder abuse, psycho-educational support group intervention, gerontology, older women, family mistreatment

PROBLEM STATEMENT

Elder mistreatment is a social problem that has received increasing recognition in recent years (Wolf, 2000). It is defined as physical, psychological, and financial abuse, and neglect of an older adult at least 60 years of age by a family member, friend, or acquaintance (Wolf & Pillemer, 1984). Estimates of prevalence rates range from 4-10 percent (Pillemer & Finkelhor, 1988; U. S. House of Representatives, 1990). The 1998 National Incidence Report estimated incidence of elder abuse as 1.9 percent (NCEA, 1998), which is considered low by some experts in the field.

The current demographics of population aging in the United States suggest that the adult population aged 60 years and older will continue to increase as the baby boomers (those born between 1946 and 1964) reach old age (Federal Interagency Forum on Aging-Related Statistics, 2000). If the percentage of older people who are abused by family members remains stable, the numbers of elder abuse victims can be expected to increase as well.

Women are especially challenged in the process of successful aging because of a number of factors, including inequities in financial resources, the assumption of family caregiving responsibilities, and societal ageism that celebrates youth over maturity (Garner, 1999). In addition, the widespread abuse of women of all ages has been well-documented (Vinton, 1999). This includes older women, who have been reported as vulnerable to abuse by adult children (Brownell, 1998), as well as partners and spouses.

Early studies of elder mistreatment suggested that care dependent older adults were most likely to be abused by overwhelmed caregivers (Steinmetz, 1988). Other studies, notably a large scale prevalence study conducted in Boston, challenged the findings of these early studies (Pillemer & Finkelhor, 1988), suggesting instead that caregiving older adults were most at risk of abuse by those impaired family members for whom they were providing care.

According to Bergeron (2001), theories that practitioners hold about the etiology of social problems of clients they serve shape their practice in the field. Those practitioners who believe that elder abuse is associated with caregiver stress may support interventions that provide relief to caregivers of care dependent older adults. Respite services, caregiver support groups, and use of formal services to supplement informal family care are examples of service interventions that evolve from this theoretical orientation. Elder abuse victims

who do not match this profile of frail and care dependent older adults may be overlooked by these practitioners.

Proponents of abuser impairment or deviance as associated with elder abuse may advocate for interventions that draw on the legal and criminal justice system. Practitioners who work with older abused women may be unsure as to whether to engage domestic violence or aging service networks as part of their interventions (Vinton, 1999). In addition, practitioners have noted that older victims of family abuse often resist interventions that they believe may harm their abuser, and often deny the seriousness of the abuse.

This response pattern is well-known in the field of domestic violence, where victims may resist or deny abuse by spouses or partners. While remedies exist in the criminal justice system, domestic violence victims may choose not to utilize them. Reasons include concern for the well-being of the abuser, fear of the abuser, lack of understanding about the dynamics of domestic violence, sense of social isolation, and lack of knowledge about the range of remedies and coping strategies that may be available.

For elder abuse victims, or victims of family mistreatment, barriers to obtaining services may include physical and cognitive frailty, and dependence on the abuser. However, victims may also serve in a caregiving or support capacity to their dependent, abusive family members, creating different but nonetheless challenging barriers to the victims' acceptance of needed services for themselves (Brownell, Berman, & Salamone, 1999). Remedies such as legal guardianships and other protective services intended for the mentally and physically impaired adults (Quinn & Tomita, 1997) are not appropriate or available for cognitively unimpaired elder abuse victims. Crisis or empowerment oriented services may not be available to unimpaired older women who are victims of family mistreatment.

The dynamics of domestic violence or family mistreatment can continue into old age as a pattern of coercive control that one family member exercises over another through physical violence, threats, emotional insults, and economic deprivation (Schechter, 1982). However, the issues that must be confronted by older women who are abused or mistreated are complicated by the dynamics of families in later life and the normal tasks of aging (Vinton, 1999).

In the domestic violence field, the psycho-educational support group has been used as an intervention for women who are domestic violence victims (Podnieks, 1999). However, this model is not commonly available to older women who may be abused by impaired family members for whom they are providing care or support, and may require adaptation to the special needs of older women who are victims of family mistreatment.

Few programs for domestic violence victims have been evaluated for effectiveness using sound research methods (Chalk & King, 1998). This gap is even

more pronounced for elder abuse service interventions. A study by the National Research Institute found that only two evaluations of elder abuse programs met the standard for sound evaluative research as defined by the Committee on the Assessment of Family Violence Intervention, convened in 1994 to assess the gap between research resources and policy needs related to addressing the problem of domestic violence, including elder abuse (Chalk & King, 1998). In addition, no evaluations to date have been undertaken for elder mistreatment psycho-educational support group models as an intervention strategy.

The study presented here is intended to address the gap between research resources and policy needs by evaluating the outcome of an elder mistreatment psycho-social support group model for cognitively unimpaired older female victims of mistreatment by family members and significant others for whom they are providing care or support. External outcome objectives for support group participants were: Increase in social network and increase in locus of control (efficacy). Internal outcome objectives for support group participants were: Increase in self-esteem, decrease in depression, decrease in anxiety and somatization, and decrease in guilt. The support group model used for the study replicates a model designed by NOVA House, an elder abuse shelter program in Manitoba, Canada (Schmuland, 1995). The study was funded by the Hartford Foundation Geriatric Social Work Faculty Scholars Program.

RESEARCH QUESTIONS

1. Does a psycho-educational support group make a difference for older women (age 60 years and older) who are victims of family mistreatment?
2. As compared with a control group, do older women who participate in an 8-week, 2 hour session per week, elder mistreatment psycho-educational support group demonstrate the following:

- Increased sense of control (measured by Health Locus of Control Scale)?
- Increased sense of social support (measured by Medical Outcomes Study Social Support Survey)?
- Decreased depression (measured by CES-D 10)?
- Decreased anxiety and somatization (measured by BSI-18)?
- Increased self-esteem (measured by Rosenberg Self-Esteem Scale)?
- Decreased guilt (measured by Guilt subscale in Multi-Problem Screening Inventory)?

The study was also intended to develop a socio-demographic profile of victims of elder mistreatment who are candidates for participation in support group interventions. This included race/ethnicity; age; income; educational level; marital status; living situation; work history and status; religious affiliation; relationship with abuser; history of abuse with identified abuser; physical and emotional functioning (measured by SF-36 Physical Functioning (PF) Scale and Rand-36 Role Physical (RP) Scale; SF-36 Role-Emotional (RE) Scale; SF-36 Social Functioning (SF) Scale; SF-36 General Health (GH) Scale); religiosity (as measured by Duke University Religion Scale); substance use (measured by SMAST-G; Drug Use sub-scale: Multi-Problem Screening Inventory); type and intensity of abuse experienced (measured by abuse sub-scales: Multi-Problem Screening Inventory); attendance at elder mistreatment psycho-educational support group sessions (measured by attendance log for those study participants randomly assigned to the intervention); and suicidality (measured by Suicidality Sub-Scale: Multi-Problem Screening Inventory).

SIGNIFICANCE OF STUDY

Elder abuse support groups are recommended as effective interventions for older victims of family mistreatment (Podnieks, 1999; Seaver, 1996). In one study, older victims of family mistreatment identified support groups as one of a few services they would accept if offered (Brownell, Berman, & Salamone, 1999). However, little is known about the effectiveness of this treatment modality (Wolf, 1998; Chalk & King, 1998).

To date, the most comprehensive study of elder abuse support groups was undertaken by the late Rosalie Wolf, who completed a descriptive study of elder abuse support groups in the United States in 1998. Dr. Wolf identified two types of support group providers: domestic violence and aging. Podnieks (2002), in a discussion of elder abuse focus and support groups from an international perspective, identified elder abuse support groups as having a number of psychosocial benefits. These include: developing mutual support relationship with peers that supplement depleted natural networks; moving beyond guilt; enhancing self-esteem; and learning problem-solving and coping strategies.

Dr. Podnieks acknowledges that these benefits are identified based on anecdotal evidence, and small provider and client satisfaction surveys. More information is needed on how support groups benefit elder abuse victims, and who benefits more than others. This is timely as there is increasing interest in elder abuse as a public health, criminal justice, and aging issue. The World

Health Organization (WHO) has funded a multi-national study on elder abuse in developing and developed countries (Dr. Gerry Bennett, Personal Communication, October 10, 2002).

The Elder Justice Bill (Breaux-Hatch, 2004) proposed funding for elder abuse services and research. The Violence Against Women's Act (VAWA) 2000 has a section on enhancing protections for older women from domestic violence and sexual assault. On the local level in New York City, the New York City Department for the Aging (DFTA) has contracted with selected community partners to provide services, including support groups, to elder abuse victims in the community (Aurora Salamone, Director, Elderly Crime Victims Resource Unit, New York City Department for the Aging, Personal Communication, December 1, 2004).

The findings of the pilot study can provide valuable information on model building and testing one approach to serving elder abuse victims through a psycho-educational support group intervention. In the planning of this pilot study, the Principal Investigator (P.I.) worked closely with DFTA's Research and Elderly Crime Victims Resource units, as well as aging service providers in New York City who have received or are interested in applying for funds from DFTA to implement service programs, including support groups, for elder abuse victims in their communities. Study findings can also inform the international community through dissemination of information at conferences, and in journals and newsletters.

METHODOLOGY

The support group sessions were held at the Fordham University Graduate School of Social Service. Pre and post study interviews were conducted for both control and intervention group participants at the agencies of community partners, and Fordham University.

The sample included sixteen (16) women age 69 to 83 identified by participating community partners as meeting the criteria for the study and agreed to participate. Nine were randomly assigned to the intervention group and 6 were randomly assigned to the control group. Eligibility criteria for study participation included: Self-identified to an aging service provider as having family problems that include family member behaviors associated with physical, psychological, and/or financial abuse; no significant cognitive impairment, based on assessments of professional social workers serving as aging provider referral sources; able to communicate in English; connected to an aging service provider with the capability to provide crisis intervention and additional

needed services; and able and willing to attend a weekly support group meeting, 2 hours in length, for 8 consecutive weeks.

The support group curriculum included content on domestic violence and older women (session one); abuse and neglect of older women (session two); the legacies of troubled families (session three); assessing family histories (session four); enhancing self-esteem (session five); dealing with depression, anxiety and stress, substance abuse, and gambling (session six); coping with loss and change in relationships with loved ones and strategies for change (session seven); and service resources and closure (session eight). Refer to Table 1 for Support Group Curriculum.

Intervention: The intervention was *a 2-hour psycho-educational support group, held weekly for 8 consecutive weeks.* A retired professional social worker and a graduate social work student facilitated the group sessions.

OUTREACH

Outreach was initiated to professional social work aging service providers who may have contact with older women at least 60 years of age who are victims of elder mistreatment as a form of domestic violence was conducted in partnership with the New York City Department for the Aging (DFTA). Service providers who agreed to participate in the study screening and referral process included the DFTA Elderly Crime Victims Resource Center, the DFTA Grandparents Resource Center, senior centers, elderly crime victims programs, the NYC Human Resources Administration (HRA) Domestic Violence Program, and the HRA Adult Protective Services Program.

DATA COLLECTION

Data for the study were collected in two ways. As part of the evaluation, in-person, pre- and post-intervention interviews were conducted two months before and after the intervention period with each study participant, including both intervention and control group participants. Each interview lasted approximately one hour, and included socio-demographics as well as measures for social network support, locus of control, depression, anxiety and somatization, guilt, substance use, religiosity, and type and intensity of abuse. While data were also collected through audiotapes of each support group session, to identify themes, and relationship between support group content and group

TABLE 1. Curriculum for Support Group

Session 1 Domestic Violence and Older Women	Session 2 Abuse and Neglect of Older Women	Session 3 The Legacies of Troubled Families	Session 4 The Silver Cord: Family History	Session 5 Enhancing Self-Esteem	Session 6 Depression, Anxiety and Stress: Feeling Bad About Ourselves; Drug, Alcohol, and Gambling Addictions	Session 7 Coping with Loss and Changes in Relationships with Loved Ones and Strategies for Change	Session 8 Closing Session
45 min.– Introduce session	15 min.– Introduce session	30 min. – Introduce session	30 min.– Introduce session	30 min.– 3 Tasks	10 min.– Present depression handouts	20 min.– Present handouts and complete activity 1	
30 min.– video: "Elder Abuse: 5 case studies"	35 min. – video: "A House Divided: Caregiver Stress and Elder Abuse"	45 min.– 3 group activities with group exercises	30 min.– 3 group activities	25 min.– synopsis of video activity 1	10 min.– discuss issues raised	10 min.– video synopsis	
20 min.– discuss video	10 min.– discuss video	23 min.– video and synopsis: "Adult Children of Alcoholics"	10 min.– video and synopsis: "Just to Have a Peaceful Life"	10 min.– discuss video	10 min.– closing round	10 min.– present and complete activity	
10 min.– closing round	45 min.– overview of Valued Traits and Vulnerabil-ities	15 min.– discuss video	30 min.– discuss video	20 min.– complete activity 2 with group	20 min.– present materials and complete activity 1	20 min.– overview of services and interventions	
	10 min.– summary	5 min.– closing round	25 min.– closing round	5 min.– closing round	10 min.– discuss issues	20 min.– role play	
	5 min.– closing round			20 min.– Present material	30 min.– Present drinking, drugs, and gampling handouts	10 min.– reflect on lessons learned	
				15 min.– synopsis of video	10 min.– discuss issues raised		
				10 min.– discuss video	5 min.– closing round		
				5 min.– closing round			

member responses, this article will report on selected evaluation data collected in the pre and post interviews with study subjects.

Data were collected using an evaluation instrument developed for the study. In addition to factual questions regarding information categories listed above, it also included scales to evaluate intervention outcomes. Scales imbedded in the instrument included the CES-D Depression Scale, the Rosenberg Self-Esteem Scale, the Duke Religiosity Scale, the Hudson Substance Use Scale, the BSI, Hudson Multi-problem Symptom Inventory (MPSI), the Social Support Scale, and the Locus of Control Scale. Some of these measures, such as the Rosenberg Self-Esteem Scale, the Social Support Scale, and the CES-D Depression Scale, have been used in evaluations of other domestic violence and elder abuse programs (Chalk & King, 1998).

DATA ANALYSIS

Interview measures were compared within and between groups to determine whether changes occurred and could be identified by comparing before and after scores for the intervention group, and between intervention and control groups, using non-parametric statistical analysis. While the small sample size precludes the possibility of obtaining statistically significant findings, it is anticipated that the findings of the pilot study will contribute to the development of a model for ongoing evaluation of elder mistreatment support groups, and some suggestion of a direction as to the effectiveness of the support group model being evaluated.

FINDINGS

Description of Sample

There was no statistical difference between the control and intervention group participants, examining socio-demographic characteristics of group participants.

Age: The average age of the 16 participants was 75-years-old: the youngest was 68 and the oldest was 83.

Race/Ethnicity: Both groups included 50% White, 44% Black, and 6% Asian/Pacific Islander (control group) or Hispanic (intervention group). The majority of study participants were born in the United States (69%), with 12.5% in Central/South America, 12.5% in Europe, and 6% in Asia.

Marital Status/Living Arrangements: Collectively, 12.5% were married, 12.5% were living together, 25% were separated, 25% were divorced, and 25% were widowed. The average length of time in the current marital status was 22 years. The majority of participants (56%) had two people living in the home, while 25% had one, 12.5% had three, and 6% had four. Nearly 90% of the participants lived in their own home/apartment, while approximately 12% lived with relatives or boarded with nonrelatives/nonfriends. The average length of stay in their current residence was 17 years, and ranged from less than one month to 46 years.
Insurance: The vast majority received Medicare and Medicaid, 94% and 81% respectively, and 81% had another kind of health insurance that paid bills in addition to Medicare/Medicaid. More than 80% of the participants reported they never lacked the kind of medical care they should have, while 19% reported they lacked needed medical care once in awhile.
Education: The average level of education completed was 13 years with the lowest level being 7 years and the highest 19 years.
Finances: The majority (72%) had a total household income less than $20,000 while for 19%, income ranged between $35,000 and $50,000. For 6% income was more than $50,000. Nearly 40% of the participants felt they did not have enough money to make ends meet at the end of the month, while 30% felt they had just enough and 30% had some money left over.
Religion: Participants were mostly Catholic (38%), while 31% were Protestant, 25% were Jewish, and 6% (one) reported no religious affiliation.
Work Status: The vast majority (81%) were not working at a paying job. Of the 19% who worked, 13% worked part-time and 6% worked 35 hours per week. Most (88%) were retired and had been for an average of 26 years. The majority (81%) did not volunteer at non-paying jobs.
Relationship with Family Abuser: The majority of participants (62.5%) identified an adult son as their abuser, 25% identified a spouse, and 6% identified a daughter and a nephew, respectively.

BEHAVIORAL TRAITS

Behavioral traits measured in the study included alcohol use, drug (including prescription drug) use, perceptions of family relations problems, relationships between victims and abusers, and type of abuse experienced. There were no statistically significant differences within or between the two groups of study participants (control and intervention) on these measures.

Alcohol Abuse: Based on the Short Michigan Alcoholism Screening Test (SMAST-G), 31% of controls and 6% of intervention participants suffered from an alcohol problem.
Drug Use: The majority (100% of controls and 89% of intervention participants) did not have a problem with drug abuse. One intervention participant was identified as having a potential problem with prescription drug use, based on the scale used in the study.
Family Relations: The majority (60% of controls and 78% of intervention participants) had family relationship problems, based on the Hartford Family Relationship Problems Subscale.
Types of Abuse Experienced: The majority, 83% of controls and 100% of intervention subjects, reported non-physical abuse, based on the Hartford Study Non-physical Abuse Subscale. Based on the Hartford Study Physical Abuse Subscale, 43% of controls and 22% of intervention participants reported physical abuse.
Suicide: None of the participants were suicidal according to the Hartford Suicide Subscale.

OUTCOME MEASURES

Participants did not differ within or between groups on the identified outcome measures utilized in the study. These included: depression, guilt, and self-esteem. There were no significant changes in these measures for either control or intervention group participants after the intervention ended.
Depression: Based on the CESB-D 10, 14% of controls and 56% of intervention participants suffered from depression.
Guilt: According to the Hartford Study Guilt Subscale, 28% of the control participants scored above threshold and 33% of the intervention participants scored above threshold.
Self-Esteem: Results from the Rosenberg Self-Esteem Scale (range is 10 to 40) indicated that participants scored an average of 32, which is above the midpoint (see Table 2).

DISCUSSION

As may be expected, the socio-demographic profile of study participants reflects a relatively unimpaired and high functioning cohort of elder mistreatment victims. This is because of the eligibility criteria for an elder mistreatment psycho-educational support group for community-dwelling victims.

TABLE 2. Outcome Measures Pre and Post Intervention

	Alcohol Abuse	Depression	Drug Use	Family Relations Problems	Guilt	Suicide	Non-phys. Abuse	Phys. Abuse
Control Pre-test	31%	14%	0	60%	28%	0	83%	43%
Intervention Pre-test	6%	56%	11%	78%	33%	0	100%	22%
Control Pre-test and Intervention Pre-test	$p = .90$	$p = .37$	$p = .37$	$p = .52$	$p = .76$	n/a	$p = .67$	$p = .33$
Control Post-test	23%	33%	0	100%	14%	0	75%	0
Intervention Post-test	6%	56%	0	86%	22%	0	83%	13%
Control Post-test and Intervention Post-test	$p = .66$	$p = .49$	$p = .37$	$p = .22$	$p = .72$	n/a	$p = .75$	$p = .41$
Control Pre-test and Control Post-test	$p = 1.0$	$p = 1.0$	$p = .37$	$p = .32$	$p = .95$	n/a	$p = .59$	$p = .09$
Intervention Pre-test and Intervention Post-test	$p = .78$	$p = .91$	$p = .34$	$p = .88$	$p = .5$	n/a	$p = .48$	$p = .58$

Criteria necessarily will screen out prospective participants who are assessed as having a high degree of cognitive or psychiatric impairment, due to the demands of this treatment model for participant capacity for group interaction, and information retention and processing.

However, the profile also challenges a perception of elder mistreatment victims that suggests they experience low self-esteem, lack of a social network support, fragile mental status, and dependency on family members for basic necessities like food, medical care, and housing. This cohort of sixteen (16) victims had relatively high self-esteem, sometimes extensive social network supports, exhibited some depression and anxiety but no suicidality, and relatively little drug and alcohol abuse, and had access to medical care through Medicare or Medicaid. Most lived in their own homes or apartments, and few identified problems obtaining sufficient food to eat. They identified themselves overall as a moderately religious group, and while most had relatively low incomes, all had some income through pensions, social security, employment, and in one case Supplemental Security Income (SSI). All were identified as having problem families, which is not surprising since experience of family abuse was one criterion for participation in the study.

Comparing their scores with *Key Indicators of Well-Being*, a national study on health (Federal Interagency Forum on Aging Related Statistics, 2000), and *Alcoholism: Getting the Facts* (National Institute on Alcohol Abuse and Alcoholism, 2004), participants presented as more depressed, more likely to use

alcohol and slightly less likely to experience illnesses associated with age but slightly more likely to identify themselves as experiencing poorer health than others their age. However, overall they appeared not to differ significantly on socio-demographic measures from others in their age cohort.

Control and intervention group members did not differ significantly on socio-demographic or behavioral measures like substance abuse, suicidality, religiosity, family problems, depression and anxiety, and family problems and abuse. Thus, any change on outcome measures of interest in the study (depression, anxiety and somatization, locus of control, perception of social network support, guilt, and self-esteem) could be attributed to the effects of the group as opposed to differences between the control and intervention group member characteristics.

Analysis of outcomes associated with the group intervention revealed no change for either control or intervention groups. In other words, there was no significant difference between control and intervention groups before and after the elder mistreatment psycho-educational support group intervention on any of the outcome measures hypothesized to be influenced by the support group experience, based on the measures used in the study. This is in spite of the self-reports of the intervention group members. All but one of the group members identified the group as helpful in increasing their self-esteem and feelings of well-being. The dissenting group member believed that the group content should be more focused on concrete problem-solving and positive visions for the future.

IMPLICATIONS FOR FURTHER RESEARCH

The study did not find any change in the hypothesized outcome measures for study participants, calling into question the effectiveness of the psycho-educational support group model for increasing the well-being of elder abuse victim participants. However, there may be alternative explanations for these findings. First, the sample size was very small (a total of 16 participants). Larger numbers of participants and groups would need to be studied to come to a conclusion about the effectiveness of this intervention model. Second, the measures used for the study may not be appropriate or sensitive enough to evaluate outcomes (either beneficial or not). Third, some of the assumptions in the literature on which the study was based may be inaccurate. Fourth, participants may benefit from longer group sessions (i.e., 12 weeks or more). Finally, participants were receiving social service support prior to the start of the study, which may have had an impact on the study: (1) those who were already receiving support may have higher self-esteem and differ in their socio-demo-

graphic profile compared with the population; and (2) they may be qualitatively different from those who did not seek/accept the support.

The socio-demographic and behavioral profile of women who participated in the group does not reflect that of the commonly accepted profile of elder abuse victims in the literature, even in the literature on support groups. This group of 16 women had high self-esteem, relatively low depression, relatively strong social network supports, and a relatively high degree of self-sufficiency before the intervention began.

Since the support group intervention was assumed to make a difference in these measures, based on assumptions about the target population that was not found to be accurate, perhaps different measures should be used to assess effectiveness in the future. Also, it suggests that either this was an atypical group of subjects, or that more information is needed about the psycho-social status of this cohort of older woman abuse victims before more effective interventions can be designed and tested.

Institutional Review Board issues: University-based research on elder abuse faces a number of ethical and methodological challenges (Dresser, 2003). Concerns on the part of University institutional review boards (IRBs) charged with the responsibility for ensuring the protection of human research subjects, particularly those identified as vulnerable, places limitations on the level of research inquiry into the social problem of elder abuse. In the study described here, the Fordham University IRB felt strongly that to ensure adequate protection for participating elder abuse victims, safeguards needed to be in place to ensure that their safety and well-being was maximized. As a result, one requirement for the study was that each study participant be served by a social worker in an agency setting during the course of the study.

A second requirement was that all subjects continue to receive social services through their identified social work and social service agency, so the intervention studied was an additional service. The levels of service subjects received in addition to the psycho-educational support group intervention was a variable for which that the researcher could not control. Because agency records are confidential, and a waiver of confidentiality was not sought in this research project, the concurrent services any given subject might have been receiving were not included in the study design.

Serious ethical concerns would likely arise for any research project on psycho-educational support groups conducted in the community that attempted to prevent subjects from obtaining additional services available to them. However, by including a measure of these concurrent services, subsequent outcome studies could help to identify an interactional effect, if any, among the intervention of interest and other interventions, if any, that subjects received concurrently.

CONCLUSION

The pilot study presented here was among the first to examine the effectiveness of an elder mistreatment psycho-educational support group model under experimental conditions, using subjects randomly assigned to control and intervention groups, and outcomes measured through pre and post tests. The study found no change in hypothesized outcomes between the control and intervention groups. Because of the small sample size of the study (a total of sixteen participants), findings are not conclusive and further research is needed.

Of interest is the information on the profile of the study subjects that challenges assumptions about the cohort of elder mistreatment victims that could benefit from a psycho-educational support group intervention. The subjects that volunteered to participate in the study had high self-esteem, as a group had relatively well-developed social networks, were in relatively good health for their age cohort, and were relatively self-sufficient. The socio-demographic and other measures used in the study did not differentiate these elder abuse victims from other older women in their age cohort. This in turn suggests that risk factors for elder abuse victimization are not intrinsic to the victim herself.

More research is needed on profiles of victimization as well as effectiveness of intervention strategies for different sub-populations of elder abuse victims.

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