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

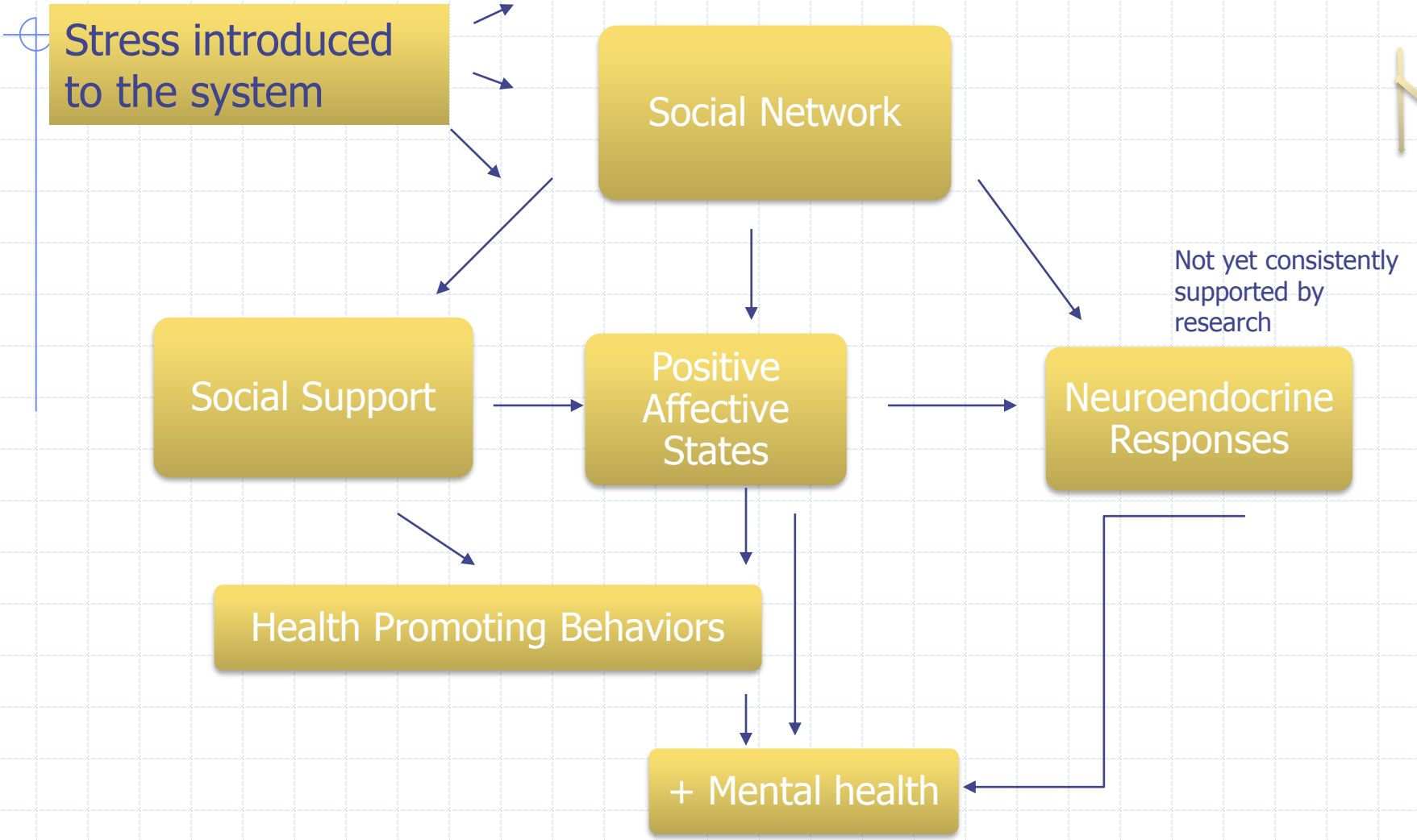
Social Support and Health

- 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.

Model 1 Main Effect Model: Social Support and Health/Mental Health

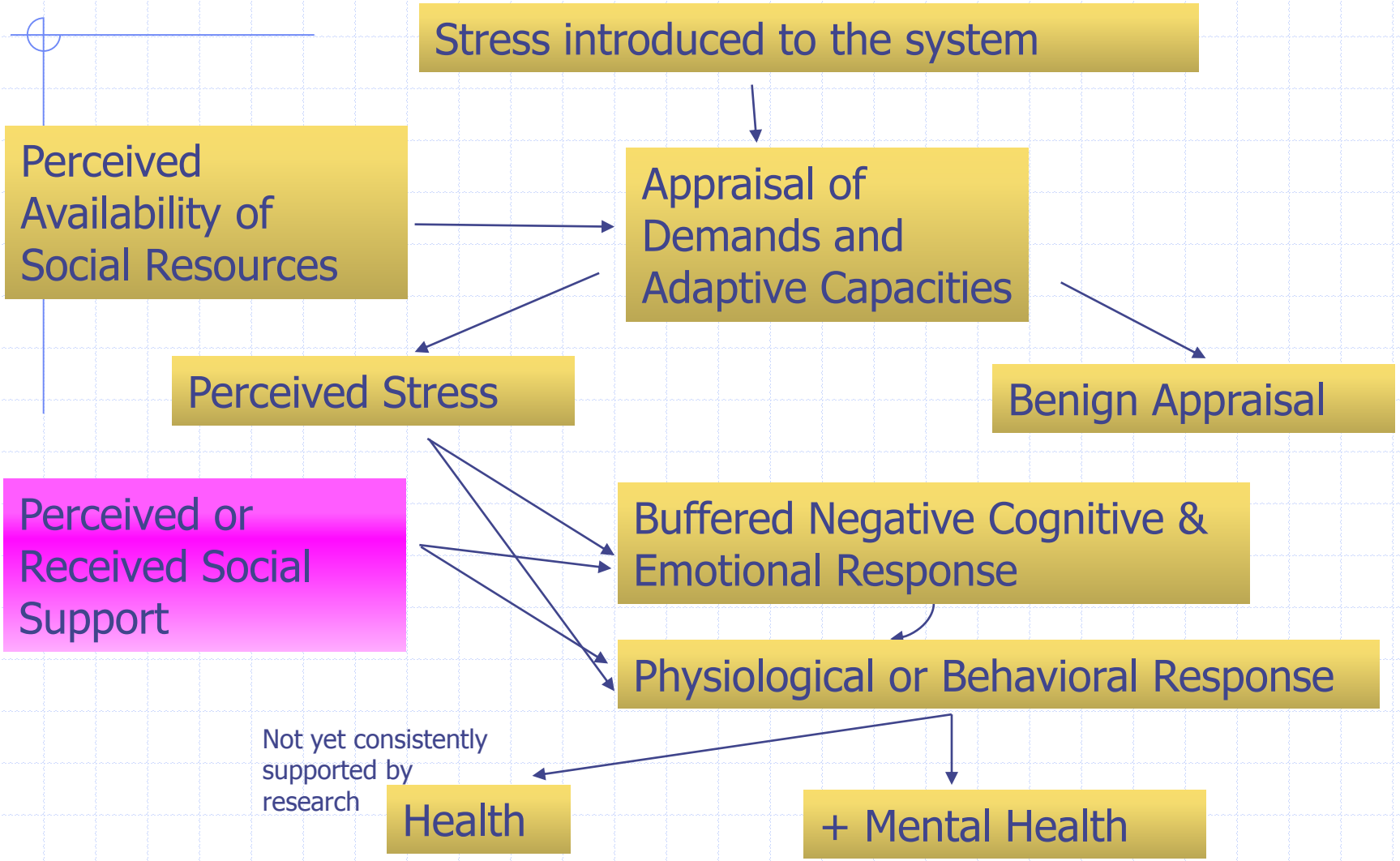


Main effect model of social ties and mental health. Adapted from Cohen S, Under- wood L G, Gottlieb BH .*Social Support Measurement and Intervention. A Guide for Health and Social Scientists*. New York: Oxford University Press; 2000.

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-bufferingmodelofsocialtiesandmentalhealth.AdaptedfromCohenS,Un- derwoodLG,GottliebBH.*SocialSupportMeasurementandIntervention.AGuideforHealthand Social Scientists*. New York: Oxford University Press; 2000

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

The 2004 Florida Hurricanes and Older Adult Mental Health

Psychological Sequelae Resulting From the 2004 Florida Hurricanes: Implications for Postdisaster Intervention

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

Objectives. Data are limited regarding mental health effects of disasters such as hurricanes. We sought to determine the prevalence of and major risk factors associated with posttraumatic stress disorder (PTSD), generalized anxiety disorder, and major depressive episode 6 to 9 months after the 2004 Florida hurricanes.

Methods. Random-digit dialing was used to recruit a representative population sample of 1452 hurricane-affected adults.

Results. Posthurricane prevalence for PTSD was 3.6%, for generalized anxiety disorder was 5.5%, and for major depressive episode was 6.1%. Risk factors varied somewhat across disorders, with the exception of previous exposure to traumatic events, which increased risk of all negative outcomes.

Conclusions. Storm exposure variables and displacement were associated primarily with PTSD. Notably, high social support in the 6 months preceding the hurricanes protected against all types of disorders. (*Am J Public Health.* 2007; 97:S103–S108. doi:10.2105/AJPH.2006.087007)

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 124 deaths and US$40 billion in costs to insured property.[1–3] 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.[4]

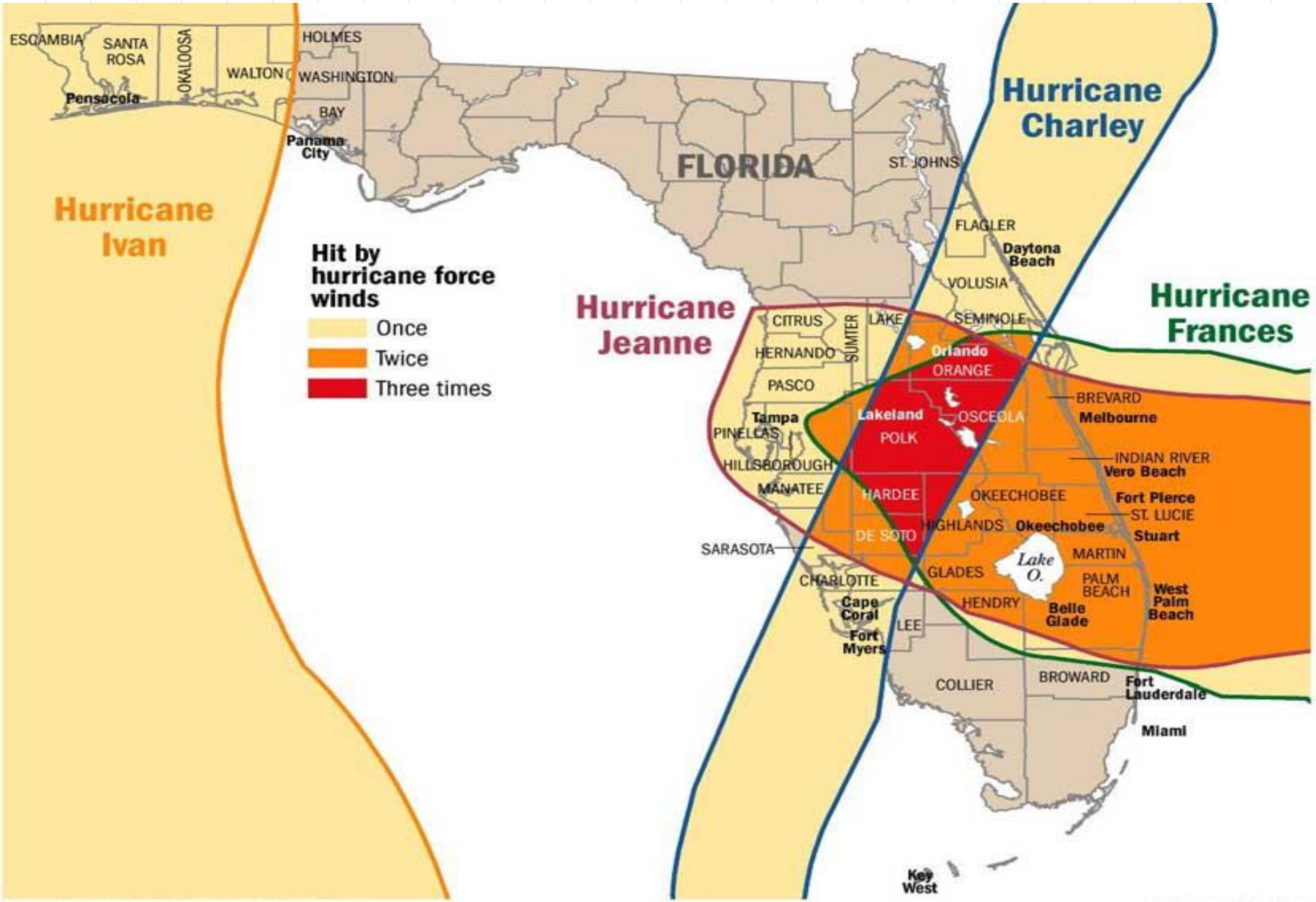
To date, the best estimates of the health-related impact of the 2004 hurricane season come from a Centers for Disease Control and Prevention report.[1] That report summarized data from a random-digit dial telephone interview conducted between November and December 2004 with a sample of 1706 participants 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 most important among environmental concerns associated with hurricanes; (2) nearly 20% reported at least "moderate" damage to their residence (i.e., US$500 in damage), and 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[5,6] and that negative postdisaster mental health outcomes are associated with long-term problems in health, recovery, and economic burden.[5,7–10] 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,[11] postdisaster 12-month prevalences for these disorders are likely higher. For example, Kessler et al[12] found 12-month prevalence 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[13] 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 (J. Freedy et al., unpublished data, 1991.)[14,15] 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.[10,12,13,16–18]

Paths of the 2004 Florida Hurricanes



Source: National Weather Service/National Hurricane Center

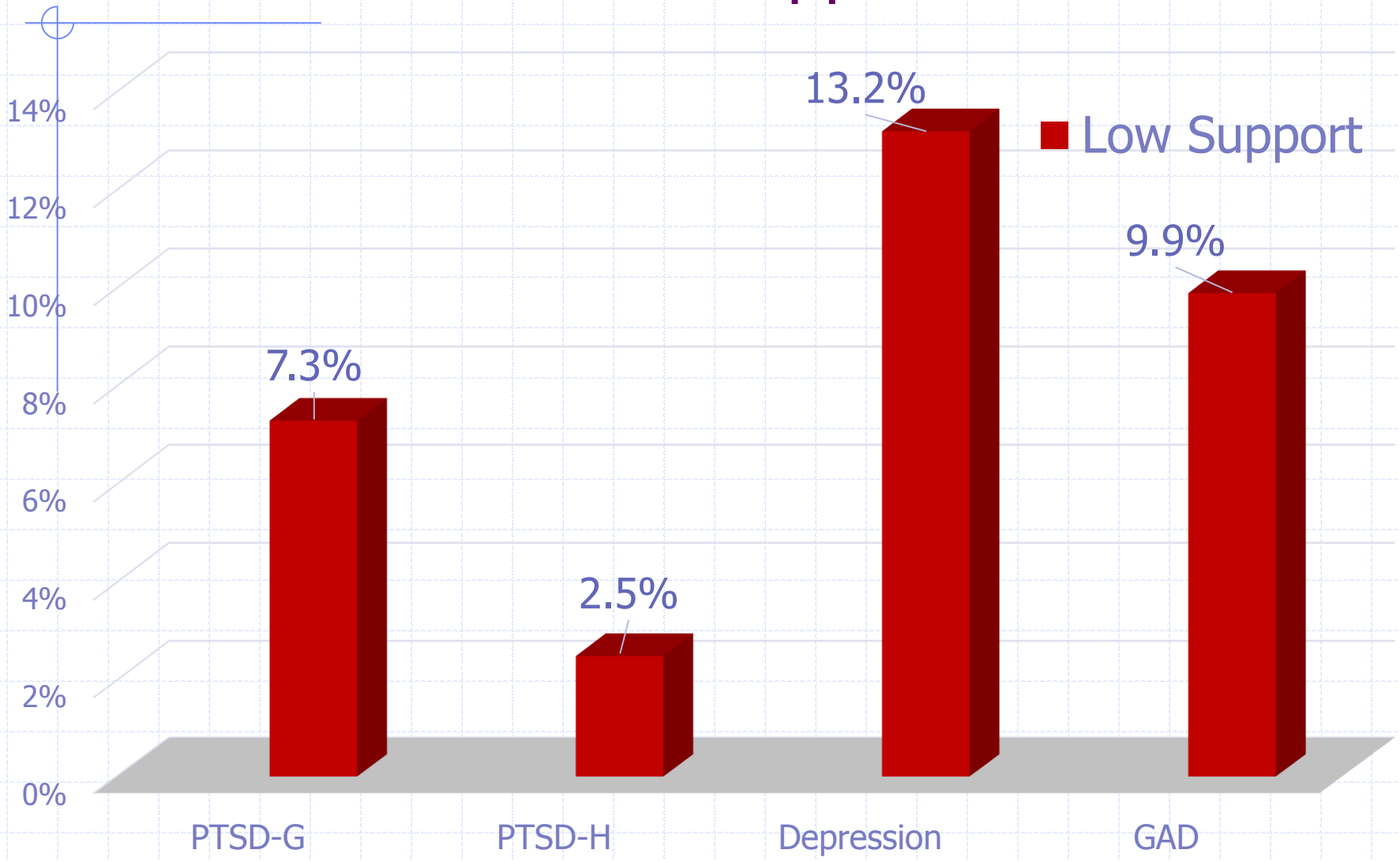
BRENNAN KING/Staff Artist

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)

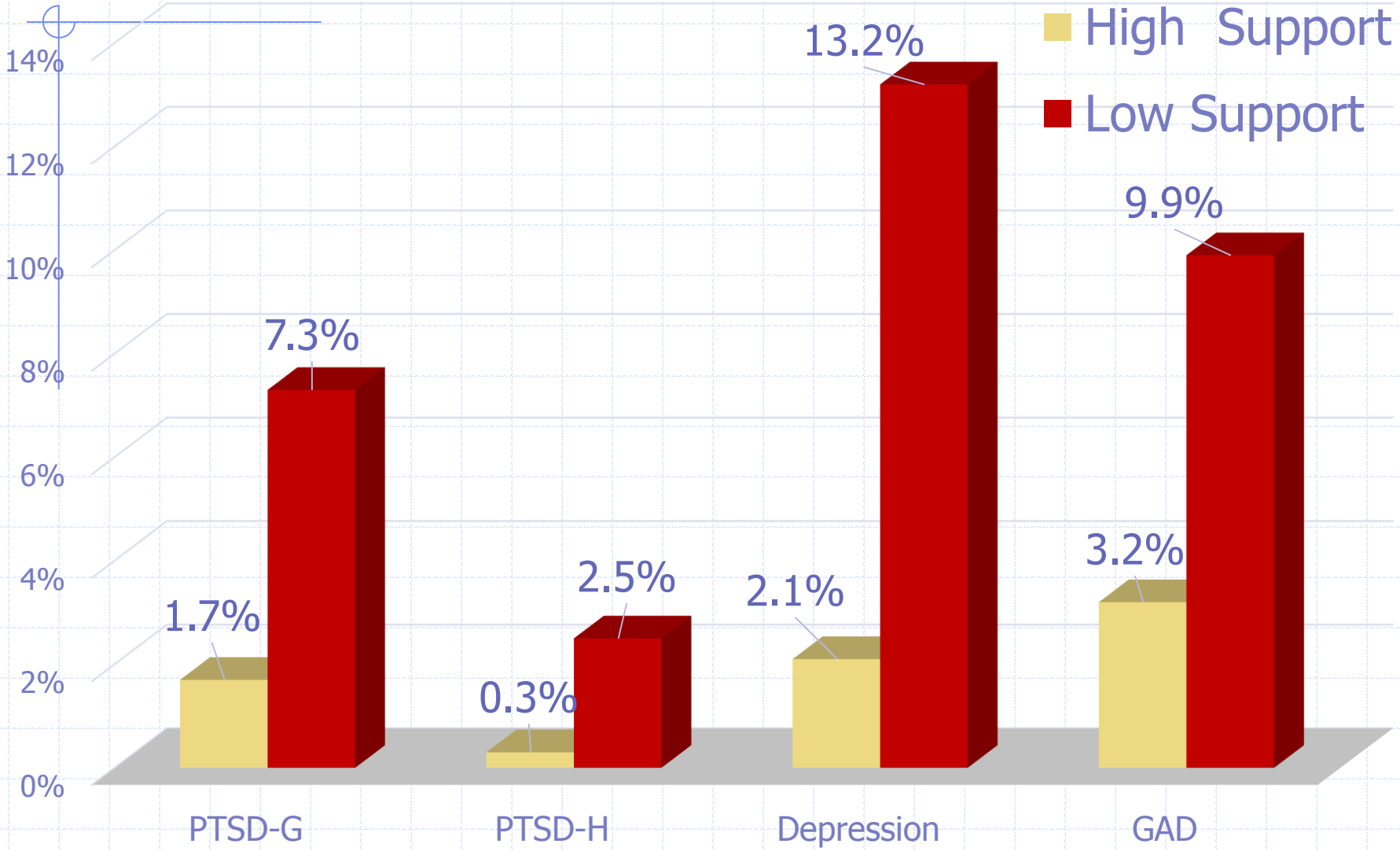
Let's take a look at mental health in those with low social support:

Prevalence of Emotional Problems in Terms of Low Social Support



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



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***


5A
5B

Treatment of Complicated Bereavement by increasing social connection

Original Article

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Behavioral Activation and Therapeutic Exposure for Bereavement in Older Adults

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Abstract

The development and clinical trial of a 5-session behavioral intervention for complicated bereavement (CB) is presented. We conceptualized CB in terms of Major Depression (MDD) and Post-traumatic Stress Disorder (PTSD) and consequently applied treatment components of Behavioral Activation and Therapeutic Exposure (BA-TE). In order to assure standardization of treatment, control costs, and engage patients, a multi-media, multi-context format was adopted to address avoidance and withdrawal behaviors conceptualized as central pathogenic responses in CB. Participants (N = 26) were assessed before and after BA-TE treatment via structured clinical interview and standardized questionnaires in terms of PTSD, MDD, CB, and health concerns. The number of days since the death of the loved one was widely variable and served as a covariate for all outcome analyses. ANCOVAS revealed statistically significant improvement, irrespective of how many days since death had elapsed prior to initiation of intervention, on structured interviews and self-report measures for most outcome variables.

Keywords

complicated bereavement, behavioral activation, therapeutic exposure, major depression, posttraumatic stress disorder, older adults

Over three decades ago, participants in a landmark study by Holmes and Rahe[1] identified spousal death as the most stressful life event experienced, a finding more recently supported by Stroebe and Stroebe.[2] Not only is loss of a loved one among the most stressful life events, it is also among the most common for older adults. Almost 1 million individuals become widowed in this country each year, and almost 75% are 65 years of age or older.[3] According to the US Census Bureau, in 2003 approximately 14% of men and 45% of women 65 years and older were widowed. Among those of age 85 and older, this increased to 43% of men and 80% of women. About 33% of surviving older adult spouses will experience a "complicated bereavement" (CB),[4,5] placing them at significantly increased risk of health problems, psychological illness, and mortality (for men).[6-9] These concerns are increased in older adults who are also experiencing reduced social and economic opportunities by virtue of their age. Indeed, impact of spousal loss is very often overwhelming for older adults; failure to provide effective services for these individuals at the time of their spouses' death represents a missed opportunity to reduce suffering, control health care costs, and improve quality of life for older adults.

Outcomes of Death in Terms of CB

Complicated bereavement, variously labeled traumatic bereavement, traumatic grief, or prolonged grief disorder, refers to a syndrome characterized by symptoms of anxiety and distress that is distinct from both normal grief and major depressive disorder (MDD).[10,11] Findings from a psychometric validation study of CB criteria reveal that core aspects of the syndrome included yearning, diminished sense of self, difficulty accepting the loss, avoidance of reminders of loss, inability to trust others, anger, numbness, feeling life has no meaning, feeling dazed/shocked by loss.[12] Overall, there is a general anxious tone to the symptom picture, complemented by emotional numbing and an inability to accept the death of the spouse or loved one. Conceptualizing CB as an anxiety-based disorder is not entirely new, however. Kavanagh[13] likened bereavement to phobic responses and reasoned further that the treatment for phobic responses (ie, exposure to feared or avoided stimuli) may be appropriate for CB.

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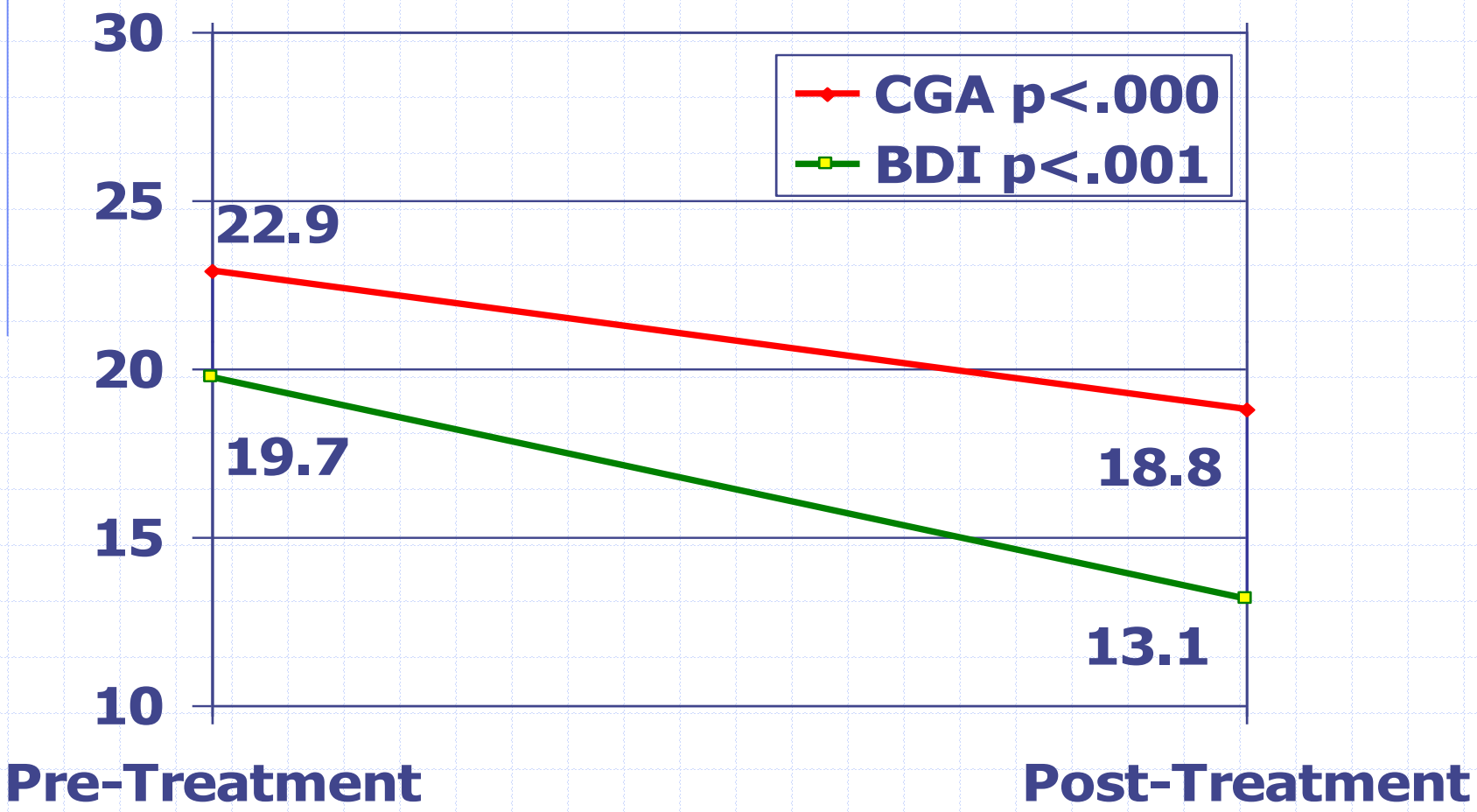
Treatment of Bereavement Using Exposure and Behavioral Activation

- 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

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The Role of Social Support in Exposure Therapy for Operation Iraqi Freedom/Operation Enduring Freedom Veterans: A Preliminary Investigation

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Abstract

The lack of social support has consistently been identified as a relevant factor in the development, maintenance, and treatment of posttraumatic stress disorder (PTSD). Prospective studies with combat veterans have supported the erosion model of social support in the development of PTSD. This model posits that increased PTSD symptoms lead to diminished social support over time. Additional epidemiological work that has investigated mental health and functional impairment in recently returning Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans has suggested that interpersonal problems coincide with the onset of PTSD. Despite research that suggests OIF/OEF veterans experience high rates of PTSD and associated interpersonal problems, no studies have examined social support in relation to treatment response in this group. The current study examined the role of four theorized functional aspects of social support— emotional/informational support, positive social interactions, affectionate support, and tangible support— on pretreatment PTSD symptom severity and treatment response in a sample of OIF/OEF veterans receiving exposure-based psychotherapy. Findings showed that positive social interactions were negatively correlated with pretreatment symptom severity, and emotional/informational support was positively related to increased treatment response. Together, these findings suggest that specific types of social support may have an important influence on the course of exposure treatment.

Keywords

PTSD; OEF/OIF; Veterans; social support; exposure therapy

Posttraumatic stress disorder (PTSD) is a chronic condition characterized by the reexperiencing of a traumatic event, avoidance of reminders of this event, and hyperarousal. A number of studies have examined potential risk and protective factors for PTSD with social support emerging as a key construct (Kilpatrick et al., 2007; Pietrzak, Goldstein, Malley, Rivers, & Southwick, 2010; Whealin, Ruzek, & Southwick, 2008; Wilcox, 2010; Zoellner, Foa, & Brigidi, 1999). A meta-analysis demonstrating that reduced social support was strongly associated with increased chronic PTSD symptoms, especially in high risk populations (Brewin, Andrews, & Valentine, 2000). Furthermore, theorists have identified social support as a key mechanism in the prevention and treatment of the disorder (Whealin et al., 2008). However, much of the research on social support and PTSD has focused on

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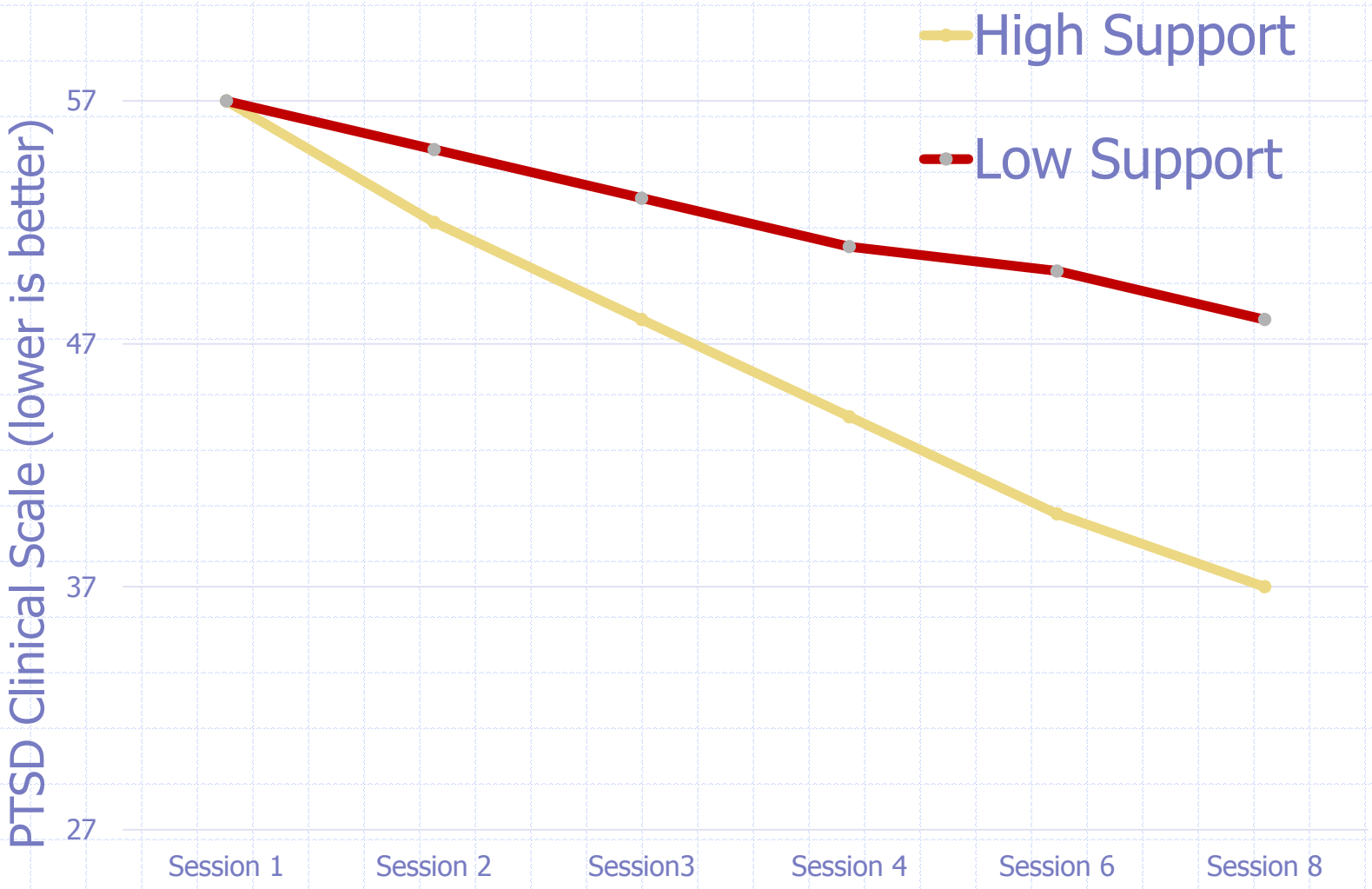
Combat Veterans Response to Treatment High Vs Low Social Support

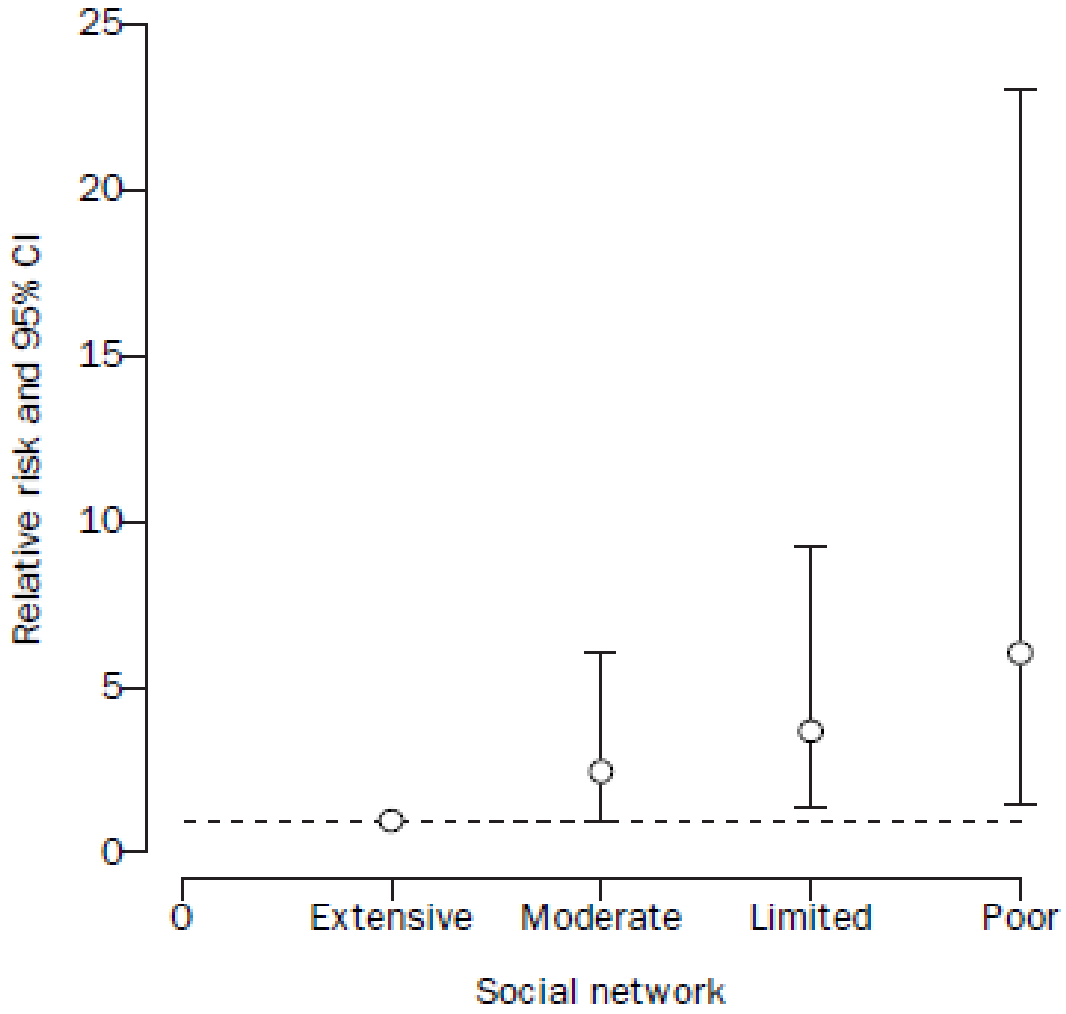


A few more examples for good measure from the work of others:

- Dementia

Social Network & Dementia

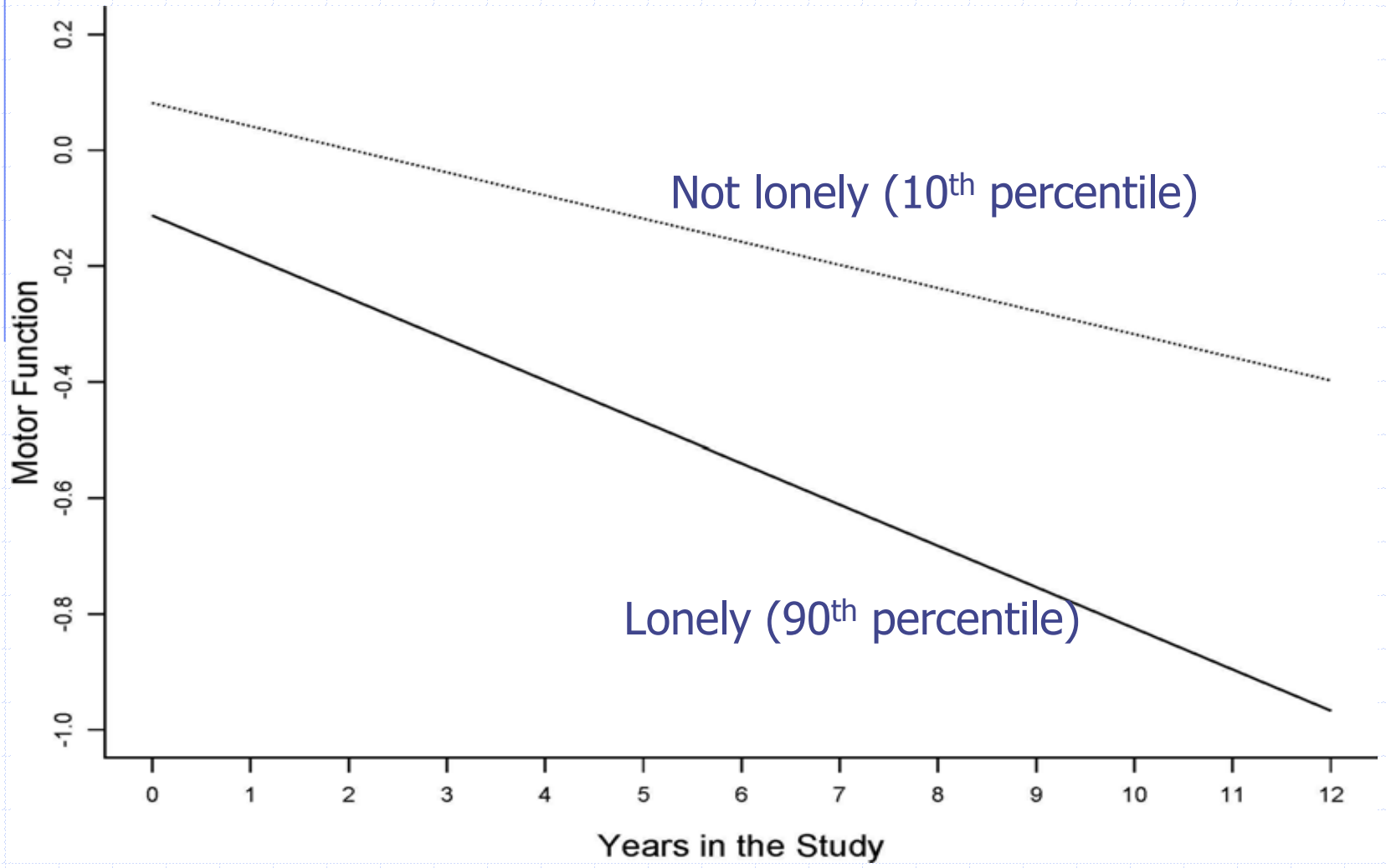
Fratiglioni, Wang, Ericsson, Maytan, & Winblad 2000



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

Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study

Ron Acierno, PhD, Melba A. Hernandez, MS, Ananda B. Amstadter, PhD, Heidi S. Resnick, PhD, Kenneth Steve, MS, Wendy Muzzy, BS, and Dean G. Kilpatrick, PhD

Objectives. We estimated prevalence and assessed correlates of emotional, physical, sexual, and financial mistreatment and potential neglect (defined as an identified need for assistance that no one was actively addressing) of adults aged 60 years or older in a randomly selected national sample.

Methods. We compiled a representative sample by random digit dialing across geographic strata. We used computer-assisted telephone interviewing to standardize collection of demographic, risk factor, and mistreatment data. We subjected prevalence estimates and mistreatment correlates to logistic regression.

Results. We analyzed data from 5777 respondents. One-year prevalence was 4.6% for emotional abuse, 1.6% for physical abuse, 0.6% for sexual abuse, 5.1% for potential neglect, and 5.2% for current financial abuse by a family member. One in 10 respondents reported emotional, physical, or sexual mistreatment or potential neglect in the past year. The most consistent correlates of mistreatment across abuse types were low social support and previous traumatic event exposure.

Conclusions. Our data showed that abuse of the elderly is prevalent. Addressing low social support with preventive interventions could have significant public health implications. (*Am J Public Health.* 2010;100:292–297. doi:10.2105/AJPH.2009.163089)

The National Elder Abuse Incidence Study,[1] conducted more than a decade ago, was the first major investigation of mistreatment of the elderly in the United States. It found that 449 924 persons aged 60 years or older had been physically abused, neglected, or in some way mistreated in 1996. 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 agents.

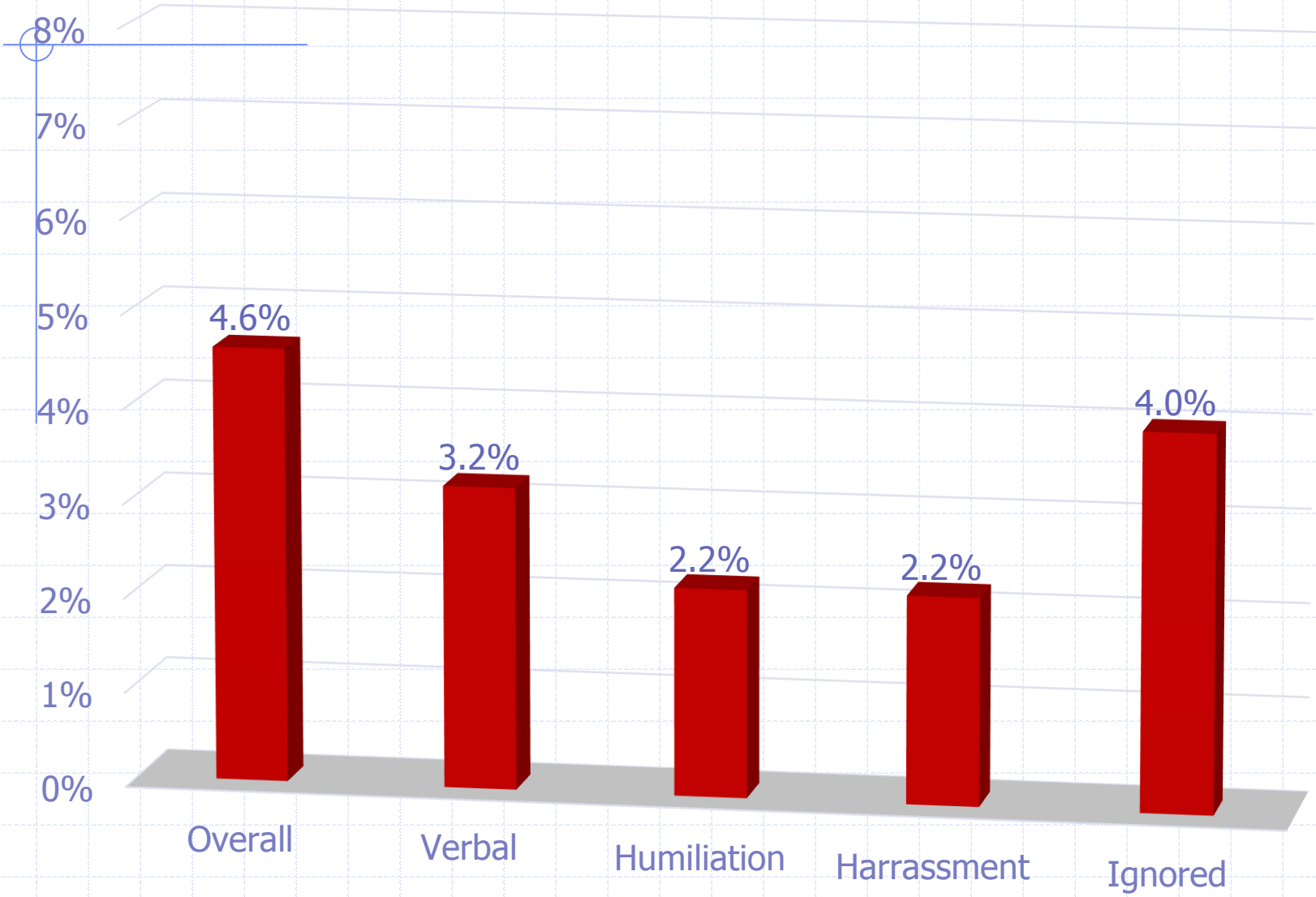
In another, earlier investigation, more than 2000 older adults in the Boston area were directly questioned about their experiences.[2] Extrapolated data indicated that approximately 1 000 000 US adults had experienced abuse since reaching age 60 years, with 2% reporting physical abuse and 1.1% verbal 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 2000 randomly selected elderly Canadians found that 0.5% suffered physical abuse and 1.4% emotional abuse since they reached age 60 years.[3] In a random sample of older adults in New Jersey, researchers found an abuse rate of approximately 1%.[4] In a sample of elderly persons in Maryland, the rate was 4.1%.[5] A study of respite care workers in Great Britain found that 45% admitted committing either verbal (41%) or physical (14%) abuse since they began working with the elderly.[6] 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 9.6% of participants.[7]

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.[8] The survey asked 3005 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.[9]

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



Significant Risk factors & Odds Ratios (OR) for Emotional Mistreatment

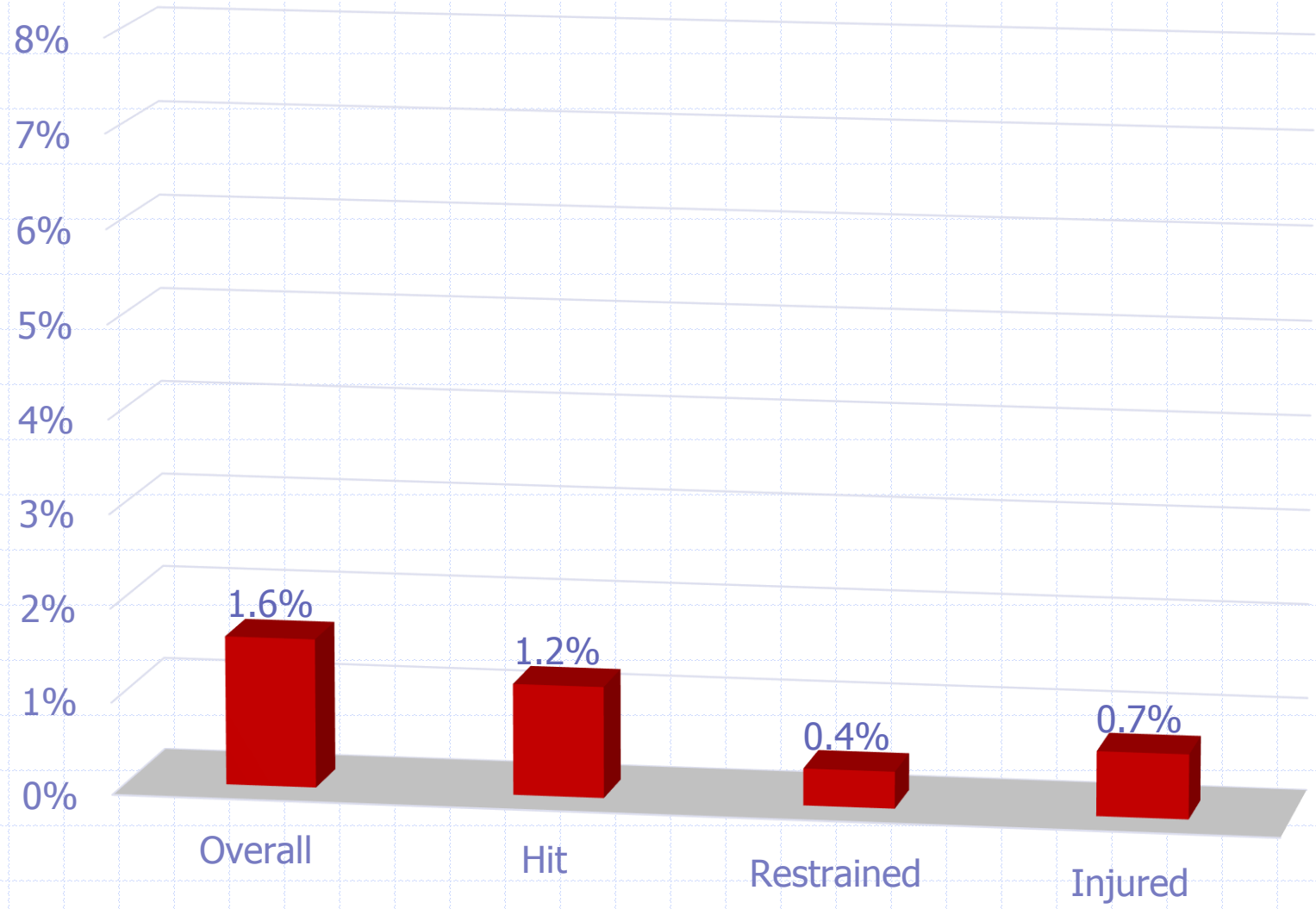
- Lower Age (OR = 3.2)
- Being Employed (OR = 1.8)
- Poor Self-Rated Health (ns)
- Prior Traumatic Event (OR = 2.3)
- Needing ADL Assistance (OR = 1.8)

- **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**

Past Year **Physical** Abuse



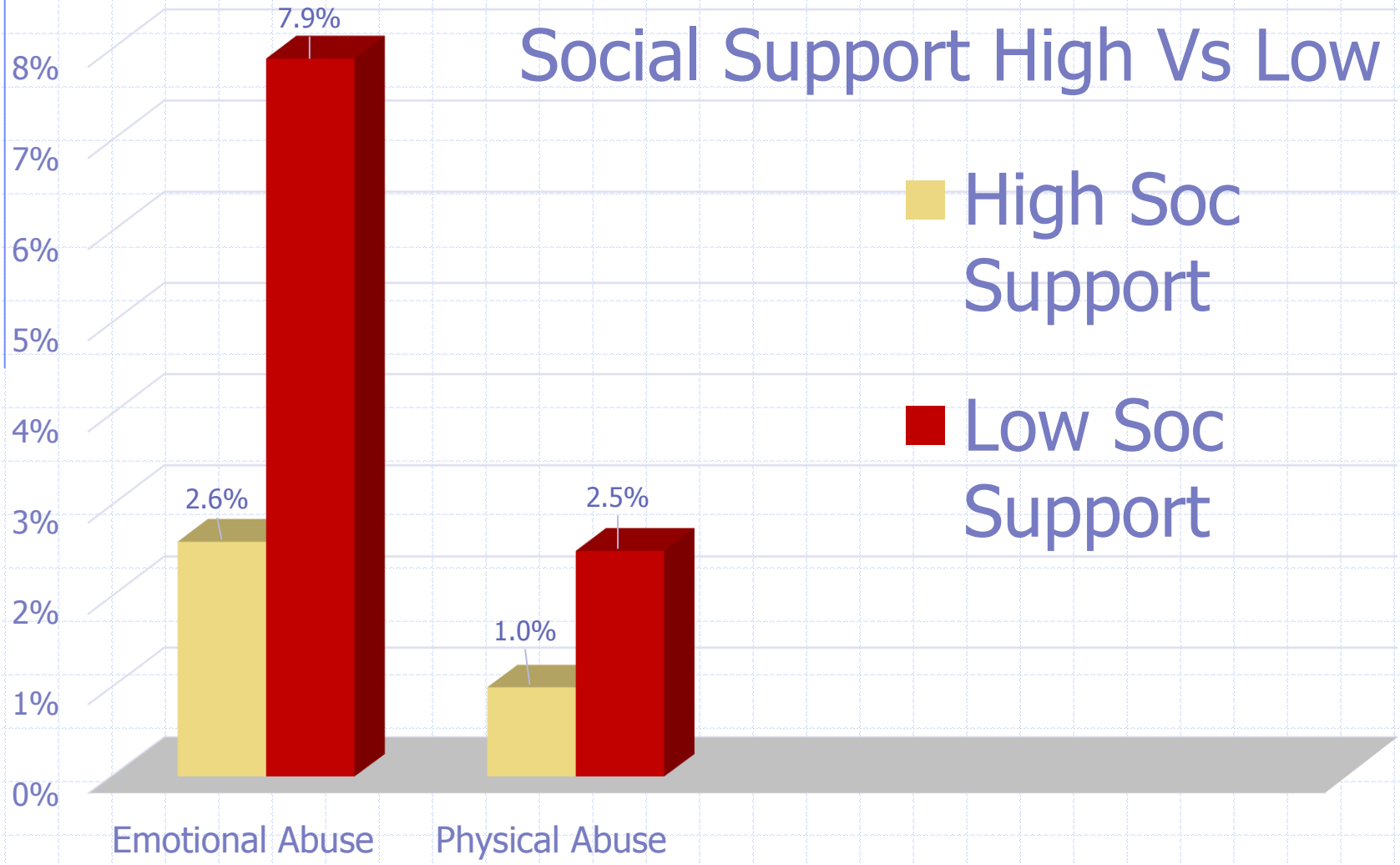
Significant Risk factors for Physical Mistreatment

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

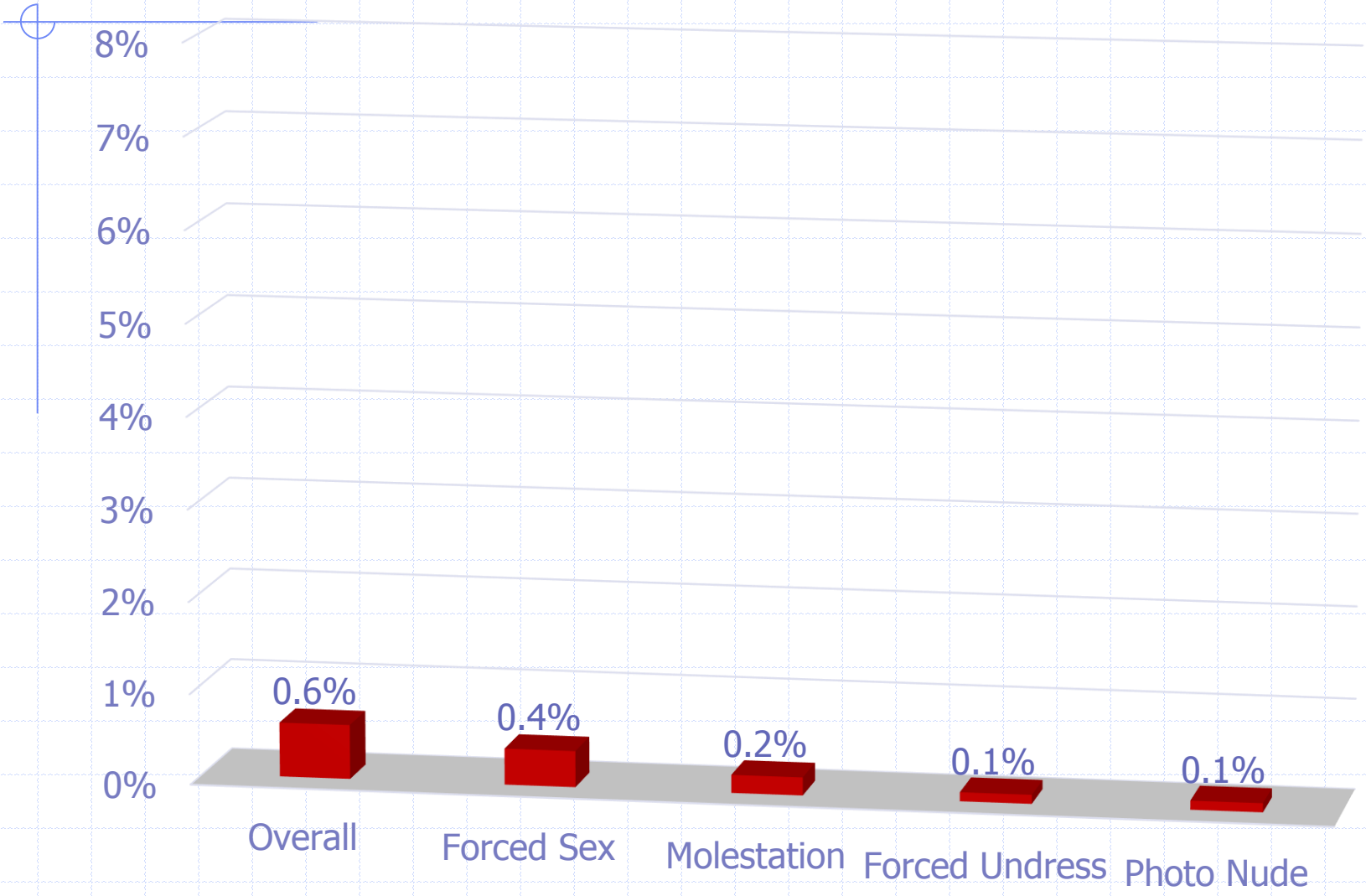
- **Low Social Support (OR = 3.0)**

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**



Past Year **Sexual** Abuse



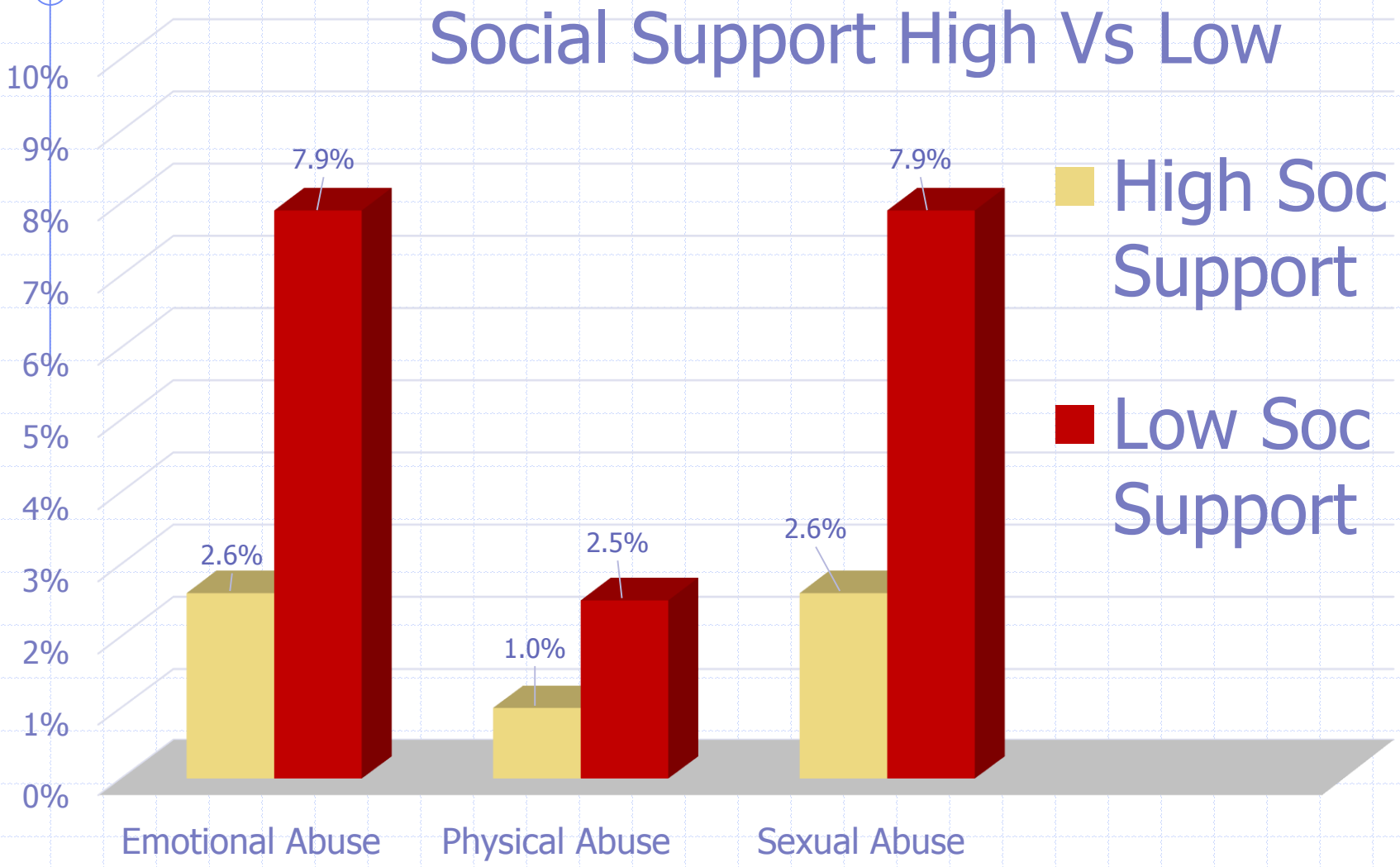
…one more time….
Let's take a look at that
Social Support Risk Factor

Sexual Mistreatment: Significant Risk factors

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

- **Low Social Support**

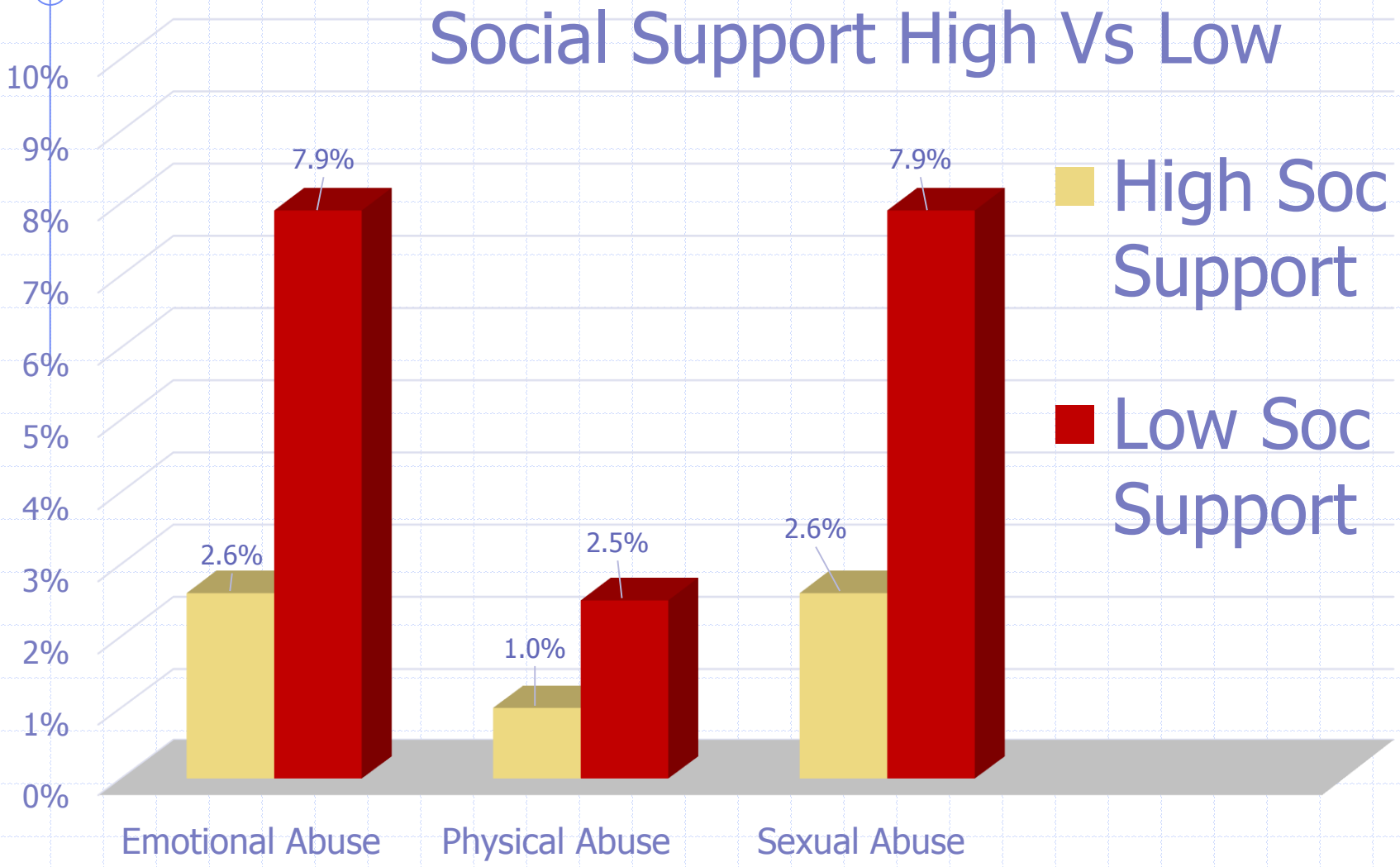
Rates of Emotional, Physical, and Sexual Abuse in terms of Social Support



Summary: Risk Factors Across Mistreatment:

RISK FACTORS	EMOTIONAL	PHYSICAL	SEXUAL
Lower Age	x	x	
Non-White			
Low Income			
Being Employed	x		
Poor Self-Rated Health			
Prior Traumatic Event	x		
Low Social Support	***x***	***x***	***x***
Use Social Services			
Needing ADL Assistance	x		

One more time….
Rates of Emotional, Physical, and Sexual Abuse in terms of Social Support



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

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The National Elder Mistreatment Study: An 8-year longitudinal study of outcomes

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ABSTRACT

Objectives: To conduct an 8-year follow-up of the National Elder Mistreatment Study (NEMS) and specify risk ratios for negative outcomes of elder abuse, including DSM-5 defined depression, generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and poor self-reported health.

Methods: Attempts were made to re-contact, via Computer Assisted Telephone Interview, all 752 NEMS participants who reported mistreatment since age 60 at Wave I, as well as a randomly selected sample of non-mistreated NEMS participants

Results: 183 NEMS Wave I elder abuse victims and 591 non-victims provided data. In bivariate analyses, elder mistreatment 8 years earlier increased risk of negative outcomes by 200–700%. However, multivariate analyses revealed that Current (Wave II) social support was highly protective against most negative outcomes (excepting PTSD), and even appeared to nullify effects of mistreatment on GAD and poor self-reported health.

Conclusions: Outcomes of elder mistreatment have not been studied prospectively in a national sample. The NEMS 8-year follow-up findings indicate a strong relationship between elder mistreatment at Wave I and negative emotional and physical health 8 years later. Fortunately, current (Wave II) social support appears to be both consistently and powerfully protective against most negative outcomes.

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Elder mistreatment; elder abuse; depression; PTSD; Anxiety

Introduction

Three recent nationally representative studies (Acierno et al., 2010; Laumann, Leitsch, & Waite, 2008), and a series of studies by Dong et al. (2010, 2014, 2013) extend the elder mistreatment knowledge base beyond that of Tatara's landmark study (National Elder Abuse Incidence Study) (1997). The largest of these studies, the National Elder Mistreatment Study (NEMS) indicated that

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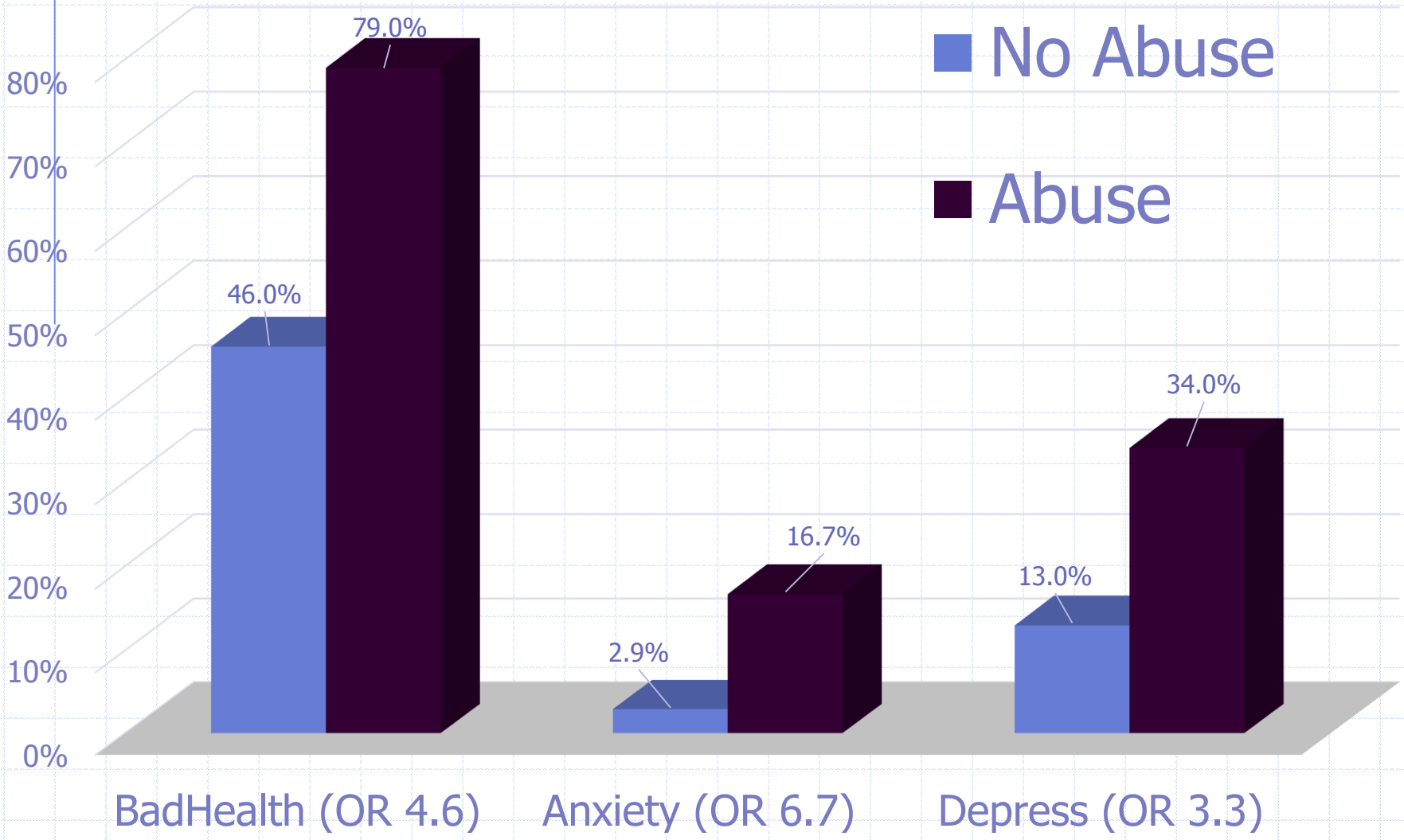
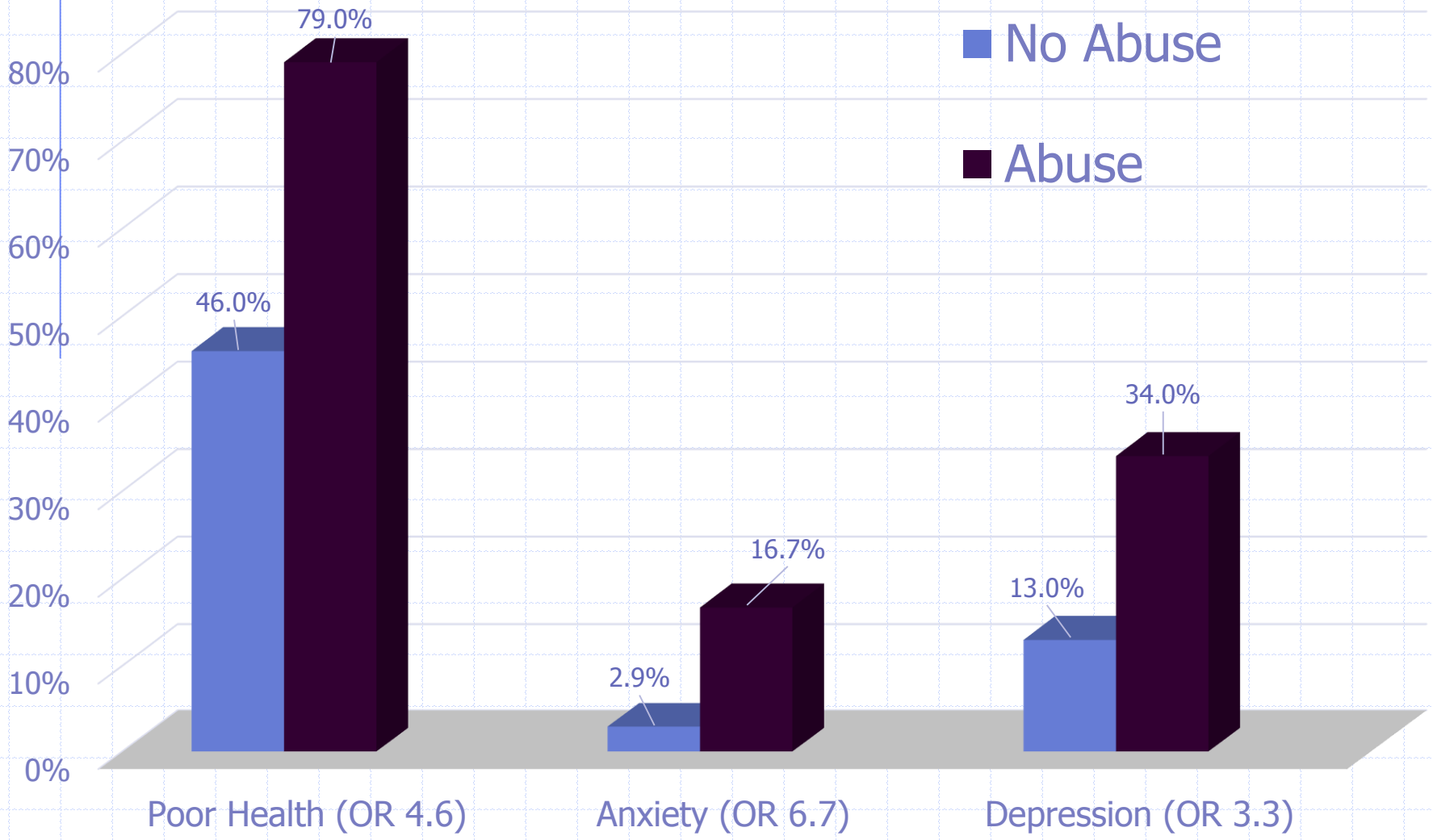
8 Years Later:
Effects of Elder Abuse in Terms of Health, Anxiety (PTSD), & Depression



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



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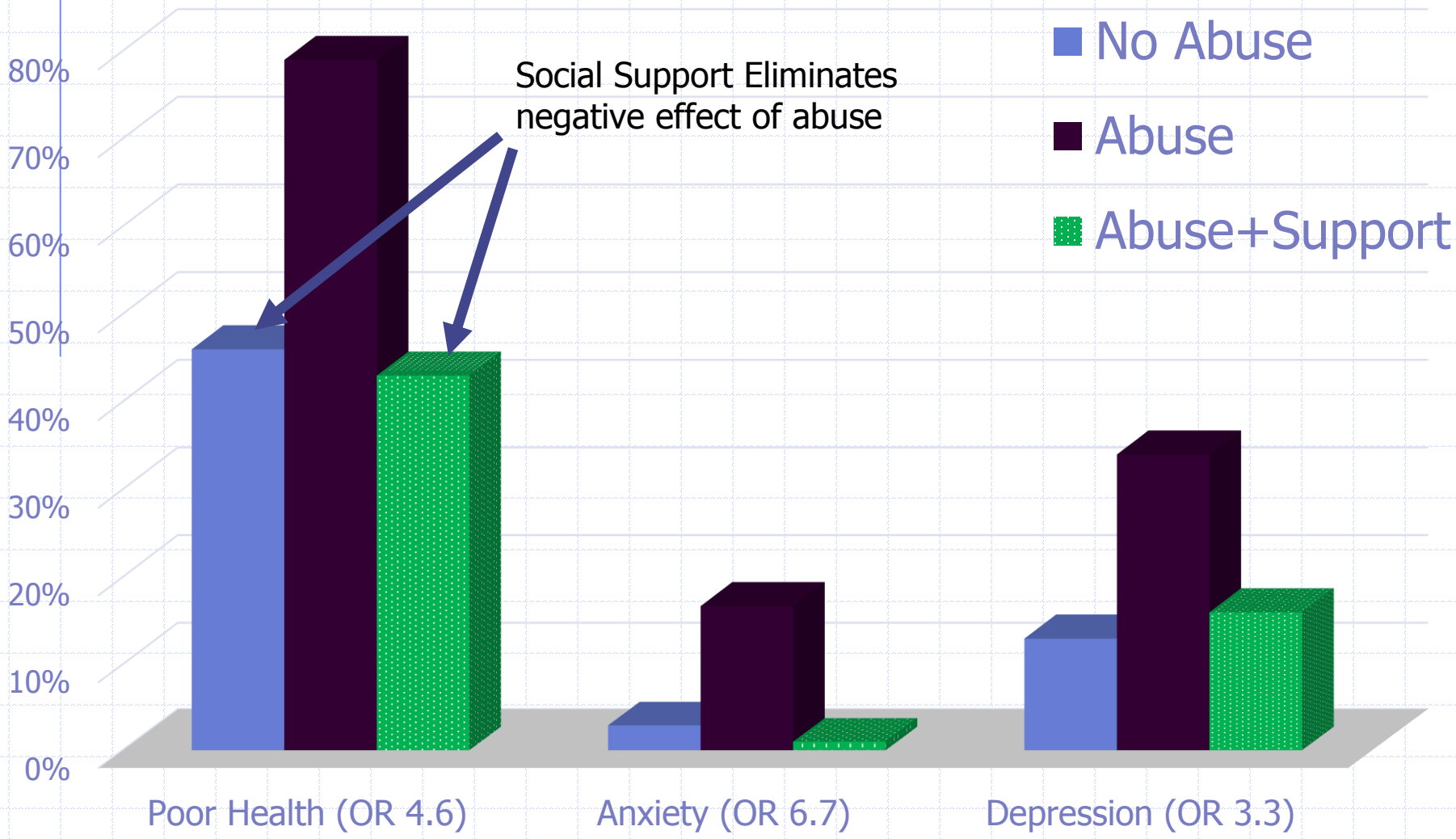

Summary: Considering Elder Abuse

- 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


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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

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**


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We need to make it easier for older adults to connect…..


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Social Support Can come in Many Forms