RE-THINKING THE CARETAKING RELATIONSHIP IN PREVENTING ELDER MISTREATMENT:

POTENTIAL ROLES FOR HELPING PROFESSIONALS AND CONGREGATIONS

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Abstract

Elder abuse takes many forms. It can be as simple as not responding to reasonable needs or borrowing money without any intent to pay it back. It can also involve actual violence. The stereotype of the dementia patient found chained to a chair in the back yard is actually a very small part of the over all elder abuse challenge to our society. To often, elder abuse evolves from persons who originally initiated elder care for caring and appropriate reasons, in this context, when mistreatment occurs, evidence suggests a large percentage of cases involve people in a dyad caretaking relationship. In this paper, we examine elder mistreatment as it occurs in the dyad caretaking relationship. We then posit re-thinking the caretaking relationship as consisting of three parties and exploring the roles of congregations in the relationship. We

conclude by offering specific recommendations for helping professionals interested in building

effective triad caretaking relationships with congregations.

Re-thinking the Caretaking Relationship in Preventing Elder Mistreatment: Potential Roles for

Helping Professionals and Congregations[1]

Connie Snyder is a 74 year old women living in a middle class suburb in a large

metropolitan area. Her husband died ten years ago. She has two sons and one daughter, Mary,

46 years who lives nearby, Mark, 48, and Alan, 51, that live out of state. Recently diagnosed

with Alzheimer's disease, Connie has had increasing difficulty caring for her self and taking care

of her home. Last week a neighbor noticed Connie standing at the mailbox at the end of the

street. When the neighbor went to check on her, it became apparent that Connie didn't remember

where she lived. The neighbor took Connie home and contacted John.

While Mark and Alan are married with families, Mary has never been married. After the

three siblings talked by phone, Mary agreed to move in to help care for their mom. At first Mark

and Alan took comfort in the fact that John was there to take care of her. Mary seemed to drive

her to church and Bible study for her usual meetings. She even did all of the grocery shopping.

Eight months after moving in, however, Alan, who kept track of his mother's finances for her,

started to notice a pattern of withdrawals from his mother's bank account. Every day, Connie

withdrew $400 from her account, which is the limit she could withdraw from an ATM. Since his

mother was a frugal person, he started asking questions. When he would ask his mother about

the withdrawals, she denied that she had done so, but clearly did not remember. When Alan

asked Mary about them, at first he denied any knowledge of them, but then suggested that she

was helping her to pay her bills.   As the ATM withdrawals persisted, Alan pushed harder to find out what was going on. At that point Mary stopped answering the phone.

At Christmas, approximately four months after the start of the ATM withdrawals, Mark and Alan arranged to visit their mother and sister. At that time, John would not let them into the house. They were met by their mother who did not seem to know them at first, but then started yelling at them that they were not going to put her into a nursing home, so they could just go away. After several attempts to gain entrance and talk with their sister, Mark and Alan began to talk with neighbors and other friends in the community and at their Lutheran Church to try to determine what was happening. One neighbor noted that the only time she sees Connie is when Mary drives her mother somewhere. However, she sees Mary from time to time with a new boy friend who seemed to be unemployed and yet able to take Mary to a lot of nice restaurants and pay cash, at least that was the rumor. When she sees Connie and Mary together, however, she noted that they seem to be doing fine. Although she offers, they never seem to need her help. When the brothers began to inquire at church they found out that Mary had been taking her mother to services, but that she had recently stopped attending. . The pastor noted that he was aware that Connie seemed to be "falling into senility" and he felt badly about that. He was also aware of a situation about three months ago when Connie last came to Bible study. Evidently Connie had been a Bible study leader for many years and one of the sharpest Bible students in the church. However, on this day during a study of the book of Exodus, she insisted that Moses was the son of God and was summarily asked to leave the group. He also noted that on another occasion when Mary had brought her mother to church, she had allowed her to put money in the collection plate, but then taken the money back out and put it in her own purse. There was a rumor that she had also started taking out more than just her mother's contributions. When he

tried to talk to Mary about it, Mary just turned and walked away. On another occasion, her

mother seemed to notice that Mary was taking Connie's money out of the plate and then she

seemed to hit her to keep her quiet.   He commented that Connie and her husband had been the

principle donors of the church organ and he did not want anyone to think badly of their family.

The pastor noted that he was not sure what he should do.

Introduction

The long-term caregiving relationship between Connie and her son John is a common

arrangement for increasing numbers of families whose elderly members need assistance. These

relationships, however, are also commonly linked to incidences of elder mistreatment. When

mistreatment occurs, evidence suggests a large percentage of cases involve people in dyad

caretaking relationships (Fisher & Regan, 2006; Fulmer et al., 2005; Hwalek, Neale, Goodrich,

& Quinn, 1996; Kosberg, 1988). As the aging of America continues, the number of elderly

entering into some type of caretaking relationship will increase. At the same time, the incidence

of elder mistreatment will also increase (NRC, 2003). In this article, the authors examine elder

mistreatment as it occurs in the dyad caretaking relationship. We then suggest re-thinking the

caretaking relationship as consisting of three parties and exploring the roles of congregations in

the relationship. We conclude by offering specific recommendations for helping professionals

interested in building effective triad caretaking relationships with congregations.

Elder Mistreatment and Dyad Caretaking Relationships

There is currently no universally accepted definition of elder mistreatment. Case in point,

there are different statutory definitions for elder mistreatment across the United States. Although

every state has some form of reporting requirements, Adult Protective Services (APS) reporting

mandates and definitions vary widely from state-to-state (Teaster, 2003). Furthermore,

perceptions of what constitutes elder mistreatment vary among different racial, ethnic, and cultural groups (Moon, 2000). In fact, the National Institutes of Health (NIH) and the National Institute on Aging (NIA), still seek research proposals to develop an understanding of elder mistreatment to assist the federal government to establish social policy that is useful across different community settings. Instead of a single definition, elder mistreatment is a broad concept that can take different forms including, physical or psychological abuse, active or passive neglect, sexual abuse, or financial exploitation (Quinn and Tomita, 1997, p. 48-49). The one common factor is the presence of a dyad caretaking relationship. The NRC (2003) specifies, "The nature of the relationship between the elder and the perpetrator lies at the heart of common understanding of the concept of mistreatment" (p. 40).

But what is it about the nature of the dyad caretaking relationship that makes elder mistreatment possible? An analysis of the NRC (2003) definition of elder mistreatment offers some clues.

> Elder mistreatment is defined in this report to refer to (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elderly from harm. (p. 40)

The definition suggests two factors that create the possibility for elder mistreatment to occur: 1) An elderly person vulnerable to chronic dependency; and (2) A caretaker with a trusting relationship with the elderly person. We set forth a third overarching factor, namely a caretaking relationship occurring in isolation.

An Elderly Person Vulnerable to Chronic Dependency

At any given time, a majority of the 35 million Americans over the age of 65 are in relatively good health. They are able to work, manage their households (e.g., prepare meals, clean, manage money), and take care of their activities of daily living (ADLs): bathing, dressing, moving out of beds and chairs, toileting and eating (Kart & Kinney, 2001, p. 106). At some point, however, many older persons experience diminished health capacities that limit their ability for self-care and self-protection. This is especially the case for persons ages 85 and older (Hooyman & Kiyak, 2002). Elder mistreatment becomes possible when people reach the point of being unable to care for themselves. This is because it is at the point of needing care that older people become vulnerable to those providing support (NRC, 2003).

Vulnerability for the elderly is a multi-faceted construct that can take different forms. Either by normal aging processes or the onset of illness, people can experience cognitive impairment, depression, or physical problems that limit daily activities (Fulmer et al., 2005). Although the symptoms causing vulnerability for the elderly are varied, the consequences of needing ongoing support are the same, namely chronic dependency.

The link between vulnerability, chronic dependency, and elder mistreatment is well documented in the literature. Kosberg (1988) identifies elderly persons who are of advanced age, experience severe physical or mental impairments, and dependent on others for care as being "high risk" for abuse or neglect. In a study of over 2000 people in Boston, Pillemer and Finkelhor (1988) found that elderly persons in poor health and being cared for by someone in the home were 3 to 4 times as likely to be abused. More recently, Fisher and Regan (2006) found that older women needing ongoing care were highly susceptible to some form of mistreatment, with a notable proportion experiencing multiple forms of abuse and neglect. Fulmer and

colleagues report that clearly elders who are more biopyschosocially limited are at greater risk of being mistreated by their caregivers (2005).

It is important to distinguish between the need for episodic help and the need for ongoing support. Opportunities to provide time-limited help are frequently welcomed by older persons and the people caring for them. For the most part, providing episodic help can be an affirmation of love and support. Moreover, there is the possibility of a reciprocal exchange of care. In contrast, few people consider the need for ongoing assistance as favorably. Quinn and Tomita (1997) describe the difference:

> Most people understand that older adults may need some assistance. But being largely dependent over long periods of time, perhaps years, is not looked upon favorably either by old people or those who must care for them. On the contrary, such dependency is often viewed with fear, dread, disrespect, shame, and disapproval. (p. 15)

Although no one is at fault, the eventual need to have ongoing assistance creates chronic dependency, a circumstance that neither elderly persons nor caretakers want, and a circumstance that increases the risk of elder mistreatment.

A Caretaker with a Trusting Relationship

As people get older, the potential need for assistance with activities of daily living increases. When needs arise, spouses and family members provide a majority (80-90%) of the care (U.S. Census Bureau, 2001). In fact, older adults have a hierarchal preference for assistance; they prefer their spouses to provide support, followed by their children, extended family members, friends, and then neighbors (Van Tilburg, 1998). Most spouses and family caretakers have a loving and trusting relationship with their elder members. During times of crisis and hardship, they are able to show great compassion and respect as they respond to the

needs for assistance. In the same way, elderly family members are usually able to express

gratitude and appreciation for the extra support.

At some point, when the need for care becomes unending, the dynamics of caretaking

relationships change. The familiarity and trust that created the caretaking relationships in the first

place, changes for both elderly persons and the persons providing support. Although some older

adults are able to maintain positive and appreciative interactions with their caretakers, others can

become frustrated. Seniors become frustrated from such things as the loss of independence

where caregivers become alarmed at with burden of dependence.   Two common scenarios often

become breaking points, one is incontinence. This is often the primary reason stated by families

for referral to a nursing home. The other reflect the competing demands on caregivers from their

own children with those of the older parent. As they express their frustration (either through

depression and withdrawal or acting out behavior), caretakers are often the only ones present. In

the same way, the extent of care needed by the elderly overtime may be more than what loving

and well-intended caretakers expected. It is one thing to provide transportation to doctor's

appointments or provide meals and companionship. It's another thing for caretakers to help older

persons who need 24hour care, may wander, become violent, or become incontinent, knowing

that the persons they are caring for are not going to get any better. In addition, caretakers face the

reality of having to balance, and in some cases forgo, other parts of their lives. The changing

interactions create relationship dynamics that are conducive to the possibility of elder

mistreatment (Pillemer & Suitor, 1992).

A key relationship dynamic conducive to elder mistreatment is the objectifying of elderly

persons over an extended caretaking relationship. After long periods of time where individuals

become more vulnerable and dependent on others, their distinctive mannerisms, quirks, likes,

dislikes, and personality traits may become less apparent. Though not intentional, caretakers may eventually lose sight of the humanness of their elderly loved ones. Instead, they may come to view the persons they are caring for with discontent, as sources of frustration and stress. In the same way, as elderly persons become more impaired, caretakers may be entrusted to handle their financial resources. Overtime, caretakers can begin to think of these assets as their own (Quinn & Tomita, 1997). One particularly vulnerable scenario is when the caregiver is financially dependent on the senior. In our case, Mary has no outside income, other than that of her mother. As her caregiver, she felt entitled to her mother's resources as a kind of payment for her time and energies. Another such scenario happens when the senior lives with family members who are dependent on the senior's social security check in order to make ends meet for the entire household. In either case the well-being of the senior seems to be come secondary to the caregivers own needs, at least financially.

A Caretaking Relationship Occurring in Isolation

At first glance, it may appear that isolation would not be an issue in the caretaking relationship. After all, no one is actually alone. From outside casual observers, there is a false sense that elderly persons being cared for and their trusted caretakers have each other. How can there be isolation? Over an extended period of progressive vulnerability and increasing dependency, it becomes clear that the relationship exists secluded from other support systems, even from other family support. In essence, elderly persons and their caretakers become shut-ins to the outside world. As Tobin, Ellor, and Anderson-Ray (1986) explain, as the need for ongoing care increases, the elderly "become isolated and homebound because they do not have access to [other people] and services that would enable them to remain active in the community" (p. 77). For the caretakers, they too become detached because or their overwhelming responsibilities in

the home. Making things even more difficult, during the limited interactions (e.g., doctor's office, church or synagogue, visits at home) that the elderly and their caretakers have with people outside the home, they often appear to be doing quite well. As often the case in our culture, when asked about how they are doing, to save face and not burden others, they usually share that everything is fine. The truth is, they may be quite lonely and feel as though they are becoming detached from their families, churches, and communities (Tobin et. al).

The misconception about isolation in the dyad caretaking relationship is also evident in how elder mistreatment is defined and examined in the literature. The NRC (2003) and other recent studies (Brownell, 2006; Jayawardena & Liao, 2006; Popa, Branch, Brown, & Schonfeld, 2006; VandeWeerd & Paveza, 2006; Wolf & Li, 1999) view mistreatment as something that occurs and can be prevented from within the relationship between a caretaker as the perpetrator and the elderly person as a victim. The problem with this view is that it does not account for the possibility that the isolated caretaking relationship is itself a major factor contributing to elder mistreatment. For present purposes, we define isolation as any trusting relationship with one main caretaker (whoever it is) and one person receiving care without open access to other systems for support and monitoring. We posit that anytime there is isolation, the situation is more conducive to elder mistreatment. Moreover, given the evidence in the literature, we suspect that with isolated caretaking relationships, it is not a matter of if mistreatment will occur, but when it will occur.

Summary of the Issues

In summary, more elderly are going to have a need for assistance and increasing numbers of spouses and family members are going to engage in caretaking relationships. Indeed, older adults prefer spouses and family members as the first option for providing care. Initially, and

with admirable intentions, most spouses and family members are able to provide assistance with patience and consideration. As the needs of older adults become more pervasive, they eventually require ongoing attention. The combination of having elderly people vulnerable to chronic dependence, their care being provided by trusted family members, and their caretaking relationships occurring in isolation, creates dynamics conducive for elder mistreatment to occur.

To prevent the expected increases (NRC, 2003; Quinn & Tomita, 1997) in elder mistreatment, the basic premises of a trusting caretaker relationship needs to be re-examined. Still the question remains, however, what should constitute a trusting caretaker relationship? Are spouses and family members the best, most available options, and so they and the older adults they care for make up the caretaking relationships? Or are there additional people and support systems that could be included? Furthermore, are certain people and support systems more suitable for participating in trusting caretaker relationships? We posit that additional people could be included in the structure of trusting caretaker relationships and, with the support of helping professions, those people could come from congregations.

From Dyad to Triad Caretaking Relationships

The notion of including additional people and supports for providing care to the elderly is not new. The specific structure we suggest, however, offers a unique alternative. A common suggestion is to set up a support team. Cason (2002), for instance, writes of developing a team to provide care. She suggests building a team of people with a set care plan that defines the needs and the roles of each person. Though we agree with her basic premises, and even agree that a team of family, friends, and professionals may be ideal, we question the reality of implementing such comprehensive teams on a wide scale basis. Will there be enough people who want and are able to participate on such teams to the extent that the structure of the trusting caretaking

relationship expands? In most cases, what is more likely to happen, is that the dyad caretaking relationship will remain the primary structure, with other persons or systems, such as home health or a nursing home involved in caregiving roles.

Another model for expanding the caretaking relationship is for the state to provide additional support. In most states, there is the intended assumption that government social services make up the external support needed by caregivers. This is equally true of most adult protective services departments. The reality is that well meaning social workers and other government providers are usually too overwhelmed by large caseloads and shortages in funding to provide the external support needed to address the isolation created in the dyad caretaking relationship. Moreover, the limitations inherent in state supported services (e.g., eligibility criteria and productivity standards for professional staff) make the scope of support better suited for a safety net of formalized care such as case management, adult protective services, and public guardianship—services which are essential, but not necessarily effective in preventing elder mistreatment (Quinn, 2005).

Instead of a comprehensive team or the formalized support of government services, we propose a middle ground where trusting caretaker relationships are re-defined as consisting of three parties. For caretaking relationships to be re-defined, each person or group needs to be perceived as fundamental and primary to the relationship. Therefore, the added person or group needs to be limited in number so that enough rapport and comfort can develop to create trusting relationships. At the same time, the additional members need to have enough emotional distance to provide accountability. For example simply adding Mary's boyfriend as a third party, since he seems to be receiving financial gain in the current context would be inappropriate. In addition, the re-defined triad caretaking relationships will also need to be linked to outside resources.

With assistance from helping professionals, religious congregations are aptly suited for joining caretaking relationships.

Congregations as Part of Triad Caretaking Relationships

Several factors make it possible for congregations to become more involved in caretaking relationships. First, congregations are already the primary avenue for older adults seeking support outside the family (Stuckey, 1997). As caretaking situations extend over time, the ties with clergy and laypeople are usually the last relationships that remain. Second, congregations are often viewed as extensions of their informal support systems, namely spouses, families, and neighbors. In fact, as people participate in congregations, their activities often build and reinforce life-long friendships (Sherr, Shields, King, & Curran, 2005). Third, congregations can serve as a meeting point linking elderly to needed services in the community. In a study of their willingness to use social services, Tirrito and Spencer-Amado (2000) found that a large majority of older adults would be more willing to use formalized social services if they were provided in places of worship. Finally, a large majority of the elderly attend religious congregations on a regular basis (The Association of Religious Data Archives, 2006). Thus the senior already has a relationship with at least some members of the congregation. In cases like that of Connie where dementia is involved, Connie may be able to recognize and even trust her pastor or a member of her congregation, where a person from a social service agency who is a stranger may be challenged when trying to establish a new relationship. Of all the groups of people that could participate in serving the elderly, congregations offer the possibility of affecting the greatest number of caretaking relationships.

Setting up Congregation Caretaking Partnerships (CCP)

Expanding caretaking relationships to include members of congregations involves empowering the elderly in churches to intentionally provide ongoing support for one another. There are five components to building effective caretaking partnerships—bring groups of elderly together on a continuing basis, educate about the realities of elder mistreatment, incorporate discussions about support, have access to pastoral or church leadership, and cultivate partnerships with helping professionals.

Bring Groups of Elderly Together on a Continuing Basis

The process of developing caretaking partnerships begins well before there are needs for ongoing support. People need time to develop enough trust to get intimately involved in caring for each other. We recommend creating groups of 10-12 people that meet at least once a week (Toseland & Rivas, 2004). Many congregations already have groups where the elderly meet on a continuing basis for fellowship, bible study, or other ministry purposes. In such cases, there is no need to create additional groups. One intentional way to develop this would be to develop a caregiver's support group that can then develop triad relationships between caregivers and church staff or other caregiving individuals. In this way the third person can take a traditional advocacy role in the relationship with the original members of the dyad. If the membership for some of these groups is quite large, create occasions for members to divide into sub-groups. In addition, as the groups continue to meet, make sure there are opportunities for informal social interactions.

Educate about the Realities of Elder Mistreatment

At some point in the meetings of the group, present information about caretaking and elder mistreatment. The purposes of presenting this information are threefold. First, educate group members on the "how to's" of mistreatment. The elderly need information on how to

identify abuse, neglect, and exploitation, and how to report a possible incident of mistreatment. Second, make the group aware of the potential for mistreatment when spouses and/or family members provide caretaking in isolation. The elderly need to understand that even with the best of intentions, when spouses and/or family members are providing ongoing support on their own, mistreatment is more likely to occur. Third, discuss how the group can help minimize the risk of elder mistreatment by creating caretaking partnerships with each other. When someone in the group develops a need for ongoing support, the group will plan on joining spouses and/or family members in providing and monitoring assistance.

Incorporate Discussions about Support

As a follow up to presenting information about elder mistreatment, the members can decide if they want to be apart of a Congregation Caregiving Partnership (CCP). If so, the group can transition into a discussion about their own support. The discussion may be the first time some members have ever considered the kinds of support they would want as the need arises. Other members may already have talked about it with their spouses, families, or friends. For the purposes of the group, it is important for everyone to have an opportunity to candidly share what they hope would happen if and when they need ongoing care. Depending on who is specifically in the group, the discussion can be about the ability and expectations for spouses, children, extended family members, and friends. The group also needs to talk about financial matters— who currently pays the bills, who has access to their assets, and how do they want their finances handled when they are unable to manage them on their own. If there is enough cohesion and trust between the members, we even recommend giving the group a candid assessment of their financial well-being. The idea is not to be invasive, but to provide fellow members with enough information to allow the group to participate as part of trusting caretaker relationships. Once the

group has a reasonable grasp on what everyone might eventually need and/or want for support, members are encouraged to share their intentions with other family and friends to have the group be involved in providing care.

Have Access to Pastoral or Church Leadership

Caretaking partnerships are going to need access to additional people and resources in the congregation and community. To that end, Pastors and key church leaders and/or community social work consultants are essential for partnerships to stay connected with the rest of their congregations. Their support can occur in different ways, but the "*message of support*" needs to be the same, namely that the groups know that someone in church leadership is specifically invested in assisting them. One option is to have a church leader included in the membership of the group. If pastors or leaders are old enough where they naturally fit, groups will already have the necessary access. If the pastors or leaders involved are of a different age cohort, the group can possibly invite a local social worker or other objective and informed person to participate. As participants, their role is to serve as a representative and a link to the rest of the congregation. As a representative, the pastor or church leader will serve as a spokesperson to keep the other leaders informed. They will also link the needs for assistance and support in the partnership to creating opportunities for other members of the congregation to serve.

Another option is for the partnership to function on its own without direct participation of a pastor or church leader in every group. Instead, one or two people from the group can meet with a pastor or church leader each week. The meetings may be brief or more involved depending on what is occurring with the caretaking needs of each group member. Either way, we suggest preserving a set meeting time to create a culture of the group linking to the rest of the

congregation and the congregation staying connected to the group through a pastor or church leader.

Cultivate Partnerships with Helping Professionals

As much as caretaking partnerships need someone to connect them to their congregations, they have to somehow acquire knowledge of, and access to, people, resources, and services in the community. We suggest members of partnerships identify key personnel in a few agencies likely to, at some point, become involved in elder care. Organizations and agencies commonly present in communities include, Area Agencies on Aging, Meals-on-Wheels, Department of Social Services, hospitals, clinics, and recreation/fitness centers. In some cases, the pastors or other members of the congregation may directly or indirectly know of a helping professional at one of these agencies. Other groups may have members who know of a social worker, a counselor, a nurse, or a doctor, who would have knowledge and access to other helping professionals. If no one in the group or the congregation has ties to a helping professional, then have one of the members call an agency that provides service to the elderly and request to speak with a social worker.

After someone makes initial contact, ask to schedule a meeting where a few members of the group can come and share about the caretaking partnership. The purposes of the meeting are to cultivate relationships, build interest, and identify other professionals who might be important for the group to know. During the meeting, see if the group can get contact information for other relevant professionals in the community. Most importantly, the meeting will begin setting a precedent that publicly communicates that the entire group plans to be involved in the caretaking needs for each other. This way when someone in the group comes in contact with them for

service or support, helping professionals won't be surprised or curious as to why other people, who are not spouses or family members, are so intimately involved in providing care.

Recommendations for Helping Professionals

The realities of an aging population create challenges for everyone involved in providing care for the elderly. Helping professionals experience the challenges in their practice with increasing caseloads, difficulties coordinating the services they wish to provide with the realities of what is available, and balancing the dichotomy of providing individualized (high quality) care and efficient service. Working with local congregations offers an alternative approach to affect the greatest number of caretaking relationships. In light of the present article, creating partnerships also offers a way to support preventative community caretaking while eliminating the isolation so conducive to elder mistreatment—thus preventing further need, strain, and cost for helping professionals as well as everyone else involved. We recommend the following roles for helping professionals interested in building effective triad caretaking relationships with congregations.

- Initiate Conversation—Make congregations in the community aware that there are helping professionals available to work with them to create partnerships. Assure pastors and church leaders that CCPs are a way to partner with helping professionals to assist older members, while honoring and promoting their religious autonomy.

- Create Opportunities to Present Information—Offer to present workshops at congregations on caretaking for older members. In addition, ask to be a guest speaker for church groups for older congregants. Many churches have gatherings on Sunday evenings or during the week, where they welcome opportunities to hear from guest speakers.

Especially in regard to topics intended to enhance social functioning and proved opportunities for ministry—both provided though creating and participating in a CCP.

- Spread the Word—Make sure people in the community become aware of the advantages of working with a CCP. Consider working with congregations, civic volunteer groups, such as Rotary, Lions, or Kiwanis, colleagues in public health, local government, and non-profit organizations, to raise funds to produce and distribute information materials about CCPs.

When a CCP exists, helping professionals can participate by:

➢ Facilitating initial meetings when members of a CCP have needs that begin to require ongoing care. Initial discussions will include the elderly person, their primary caretaker, and the entire CCP. The purpose of the meetings is to help the CCP clarify roles and communicate support. The members of the CCP need to clarify roles associated with personal care, companionship, transportation, housekeeping, meal preparations, safety, and finances. Helping professionals can also help members communicate support for one another.

➢ Educating the group about the dangers of dyad caretaking relationships occurring in isolation. Assist caretakers to normalize viewing the entire partnership as part of trusting caretaking relationships. It is important to have members reinforce, from the outset, that offering accountability and monitoring of care and finances is a part of a trusting and supporting. We even recommend discussing the option of having members of the CCP conduct periodic audits of financial expenditures. Although such a practice may seem invasive, in the context of a triad caretaking relationship, it is a supportive method to

prevent financial abuse— a prevalent form of elder mistreatment that often occurs

concurrently with other forms of elder abuse and neglect (Quinn and Tomita, 1997).

➢ Assisting CCPs to complete release of information forms. If there is agreement on the

roles of the trusting caretaking relationship, then members of CCPs will want to be

included in all aspects of care and services. Therefore, when helping professionals

provide services to elderly clients, they will view the entire partnership as the primary

support system. For this to occur, helping professionals need to have elderly clients

complete and sign release of information forms for the members of the partnership[1].

➢ Being available from time-to-time when CCPs needs consultation. As triad caretaking

relationships continue over an extended period of time, they are likely to need occasional

input from trained professionals. Depending on their training and areas of competence,

helping professionals may not always be able to help the group. In such instances, assist

the partnership to seek consultation from another colleague in the community.

➢ As part of consultation, be prepared to provide and link the CCP to additional formalized

services, such as home health, guardianship, adult protective services, assisted living,

physical therapy, recreation/leisure programs, and respite care. If and when additional

services are needed, the CCP may need assistance accessing them.

Conclusion

The moral challenge presented by the aging of America's population is not just in areas

of providing basic services. Rather it reflects the need to do so with the needs of the senior truly

at the center of the relationship. Family and other informal caregivers are critical parts of the

total fabric of the care network for seniors. Yet, to simply assume that because two people are

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[1] See http://www.hhs.gov/ocr/hipaa/ for more information on releasing information.

related to one another the caregiver will always have the needs of the senior at heart has been demonstrated to be a false assumption. As a person with dementia, Connie trusts Mary. Indeed originally, her sons did as well. Only upon investigation did they realize that their otherwise well meaning sister was actually exploiting Connie and did not have her best interests at heart. By moving from the dyad as the assumed appropriate relationship for caregiving to a triad where there is an independent advocate, Connie's rights and even Mary's needs can be better adjudicated to the well-being of both the senior and the caregiver.

References

Administration for Children and Families and Administration on Aging (1998). The National

     Elder Abuse Incidence Study. Retrieved January 30, 2007 from

     http://www.aoa.gove/eldfam/Elder_Rights/Elder_Abuse/AbuseReport_Full.pdf

Brownell, P. (2006, November). Women Empowerment in Later Life (WELL): Outcomes of a

     peer education and advocacy training group for older women victims of family

     mistreatment. The Gerontological Society of America 59th Annual Scientific Meeting.

     Dallas, Texas.

Cason, A. (2002). *Circles of care: How to set up quality home care for our elders.* Boston:

     Shambhala.

Fisher, B. S., & Regan, S. L. (2006). The extent and frequency of abuse in the lives of older

     women and their relationship with health outcomes. *The Gerontologist, 46*(2), 200-209.

Freeman, I. C. (2005). Advocacy in aging: Notes for the next generation. *Families in Society,*

     86(3), 419-423.

Fulmer, T., Paveza, G., VandeWeerd, C., Fairchild, S., Guadagno, L., Bolton-Blatt, M., et al.

     (2005). Dyadic vulnerability and risk profiling for elder neglect. *The Gerontologist,*

     45(4), 525-534.

Hooyman, N. R., & Kiyak, H. A. (2002). *Social gerontology: A multidisciplinary perspective* (6th

     ed.). Needham Heights, MA: Allyn and Bacon.

Hudson, R. B. (2005). The new political environment in aging: Challenges to policy and

     practice. *Families in Society, 86*(3), 321-327.

Hwalek, M. A., Neale, A. V., Goodrich, C. S., & Quinn, K. (1996). The association of elder

    abuse and substance abuse in the Illinois elder abuse system. *The Gerontologist, 36*(5),

    694-700.

Jayawardena, K. M., & Liao, S. (2006). Elder abuse at end of life. *Journal of Palliative*

    Medicine, 9(1), 127- 136.

Kart, C. S., & Kinney, J. M. (2001). *The realities of aging: An introduction to gerontology* (6th

    ed.). Needham Heights, MA: Allyn and Bacon.

Kiplinger, K. (2007). Can we afford to grow old? *Kiplinger's Personal Finance, 61*(2), 50.

Kosberg, J. I. (1988). Preventing elder abuse: Identification of high risk factors prior to

    placement decisions. *The Gerontologist, 28*(1), 43-50.

Lamm, R. D., & Blank, R. H. (2005). The challenge of an aging society. *The Futurist, 40*(4), 23-

    27.

Moon, A. (2000). Perceptions of elder abuse among various cultural groups: Similarities and

    differences. *Generations, 24*, 75-80.

National Research Council. (2003). *Elder mistreatment: Abuse, neglect, and exploitation in an*

    Aging America. Panel to Review Risk and Prevalence of Elder Abuse and Neglect.

    Richard J. Bonnie & Robert B. Wallace (Eds). Committee on National Statistics and

    Committee on Law and Justice, Division of Behavioral and Social Sciences and

    Education. Washington, DC: The National Academies Press.

Pillemer, K., & Finkelhor, D. (1988). The prevalence of elder abuse: A random sample survey.

    The Gerontologist, 28(1), 51-57.

Pillemer, K., & Suitor, J. (1992). Violence and violent feelings: What causes them among

    caregivers? *Journal of Gerontology, 47,* S165-S172.

Popa, M., Branch, L., Brown, L., & Schonfeld, L. (2006, November). An instrument

    development for estimates of elder abuse. The Gerontological Society of America 59th

    Annual Scientific Meeting. Dallas, Texas.

Quinn, M. J. (2005). *Guardianships of adults: Achieving justice, autonomy, and safety.* New

    York: Springer.

Quinn, M. J., & Tomita, S. K. (1997). *Elder abuse and neglect: Causes, diagnosis, and*

    intervention strategies (2nd ed.). New York: Springer.

Sherr, M. E., Shields, G., King, W., & Curran, M. A. (2005). Informal vs. formal support

    networks among the elderly and the role of religion. *Social Work and Christianity, 32*(4),

    341-353.

Stuckey, J. C. (1997). A community of friends: The Sunday school class as a conduit for social

    contracts and social support among older women. *Journal of Religious Gerontology,*

    10(3), 53-71.

Teaster, P. (2003). *A response to the abuse of vulnerable adults: The 2000 survey of state Adult*

    Protective Services. Retrieved, January 30, 2007 from

    http://www.elderabusecenter.org/pdf/research/apsreport030703.pdf

The Association of Religious Data Archives. (2006). General Social Survey 2004. Retrieved

    January 30, 2007 from

http://www.thearda.com/Archive/Files/Analysis/GSS2004/GSS2004_VAR1187_1.asp

Tirrito, T., & Spencer-Amado, J. (2000). Older adults' willingness to use social services in

    places of worship. *Journal of Religious Gerontology, 11*(2), 29-42.

Tobin, S. S., Ellor, J. W., & Anderson-Ray, S. M. (1986). *Enabling the Elderly: Religious*

    institutions within the community service system. Albany, NY: SUNY.

Toseland, R. W., & Rivas, R. F. (2004). *Introduction to group work practice* (5th ed.). Needham Heights, MA: Allyn and Bacon.

U.S. Census Bureau. (2001, October). *The 65 years and over population: 2000.* Washington, DC: Author.

Vandeweerd, C., & Paveza, G. (2006, November). Mistreatment of older adults with Alzheimer's disease: A case for differentiating those who verbally and physically mistreat, and those who physically mistreat only. The Gerontological Society of America 59th Annual Scientific Meeting. Dallas, Texas.

Van Tilburg, T. (1998). Losing and gaining in old age: Changes in personal network size and social support in a four-year longitudinal study. *Journal of Gerontology: Social Sciences, 53B,* S313-S323.

Wallace, S. P. (2005). The public health perspective on aging. *Generations, 29*(2), 5-10.

Wiesensale, S. K. (2005). Aging societies and intergenerational equity issues: Beyond paying for the elderly, who should care for them? *Journal of Feminist Family Therapy, 17*(3/4), 79-103.

Wolf, R. S., & Li, D. (1999). Factors affecting the rate of elder abuse reporting to a state protective services program. *The Gerontologist, 39*(2), 222-228.

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