Journal of Cross-Cultural Gerontology (2019) 34:325–336
https://doi.org/10.1007/s10823-019-09377-5

ORIGINAL ARTICLE

Family-Centred Interventions for Elder Abuse: a Narrative Review

Jill Ryan [1] · Nicolette V. Roman [1]

Published online: 22 June 2019
© Springer Science+Business Media, LLC, part of Springer Nature 2019

Abstract

Information about elder abuse has not only been sparse due to factors such as underreporting or lack of standardized research, but also in defining elder abuse. However elder abuse is commonly understood to be a single/repeated act, or lack of appropriate action, occurring within any relationship which embodies an expectation of trust, which causes harm or distress to elderly individual. In elder abuse, the relationship of trust usually entails the family, as it family members who are noted to be the most likely perpetrators of elder abuse With the increased prevalence of elder abuse in developed countries and a proclivity towards individualized interventions, this narrative review sought to explore family-centered interventions used to address elder abuse by using a RE-AIM framework.

Keywords Elder abuse · Family-centered · Family intervention · Family violence · RE-AIM framework

Elder abuse has been difficult to define, let alone holistically understood (Ferreira and Lindgren 2008). However, elder abuse is commonly understood to be a single/repeated act, or lack of appropriate action, occurring within any relationship which embodies an expectation of trust, which causes harm or distress to elderly individual (WHO 2002; Tolan et al. 2006).

In elder abuse, the relationship of trust usually entails the family, as it family members who are noted to be the most likely perpetrators of elder abuse (Berkamn 2006; Soares et al. 2010). Research has identified that there is an interconnected relationship between the elderly and their family, with the family not only being a source of care but also abuse (Bookman and Kimbrel 2011; Berkamn 2006; Soares et al. 2010). About 4–6% of seniors experience abuse in the home, and over a third of family carers reporting perpetrating abuse (Cooper et al. 2008; Sethi et al. 2011). Cases of family carers perpetrating abuse have been attributed to carer stress and therefore the majority of family interventions are aimed at reducing the stress of carers (Cooper et al. 2008;

✉ Jill Ryan
jryan@uwc.ac.za

[1] Centre for Interdisciplinary Studies of Children, Families and Society, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, Cape Town 7353, South Africa

Tam and Neysmith 2006). In a systematic review focusing on interventions for elder abuse, only one fourth of the results showed interventions aimed towards family caregivers, with most studies showing an intervention aim towards professionals (Ploeg et al. 2009).

In understanding that elder abuse occurs mostly within the family, it seems misaligned that majority of elder abuse interventions focus on bolstering social services, service delivery and knowledge of elder abuse (Daly et al. 2011; Jagielska et al. 2015; Pillemer et al. 2007). Furthermore, service delivery or public services are notably individual-orientated than family or community focused (Parra-Cardona et al. 2007). Thus, in order to reduce elder abuse, the focus should be a family-centered approach bolstering family functioning and well-being.

A family-centered approach means the family is not only included in the intervention, but partakes in the formation of the intervention, allowing the program to be needs sensitive to the specific family. Hence, a family-centered approach creates a collaborative relationship between families and professional whereby family input is encouraged and each family is treated as unique, instead of prescriptive to a specific group (Burns et al. 2008). This view of family as a collaborator and unique in structure and functioning, denotes an efficient way to address elder abuse; as elder abuse is grounded in cultural and social contexts (Gair 2015), which has lead abuse and neglect to always be interpreted differently across cultures and context. A family-centered approach is an adequate and holistic response which acknowledges the role of family in elder abuse and its subsequent solution. It is for this reason we needed to determine what family-centered interventions addressing elder abuse were available and how this could map out possible solutions for future interventions. The aim of the paper was thus to identify family-centered interventions used to address elder abuse.

Methods

Databases searched included Google Scholar, Academic Search Complete, PubMed, SocIndex, MEDLINE, PsychARTICLES and Research Gate. Search terms included elder abuse and neglect, community-based, family, family interventions, family-centered and family-based interventions. The interventions sought were in English as well as searched from within an 11-year time frame from date of study (2006–2017) to elicit latest trends.

Articles seen to relate to the search terms, were assessed via titles, abstracts as well as article content. Articles sought for this review had to be family-centered interventions with a primary aim to address elder abuse. The interventions had to have included the elderly and at least the family caregiver. Furthermore, the intervention was to go beyond screening but also include a program referral plus a description of the program layout, with the program potentially to be implemented at community level. Furthermore, a systematic review of citations for elder abuse (Erlingsson 2007) had been referred to in order to identify specific journals which would yield results in offering more articles in terms of family-based interventions.

Results

In total 34,929 hits were found via the databases. This total excludes Research gate results, as Research gate does not provide an exact number of hits. Only 3 articles were identified via title with 1 identified through Research Gate. Of the 4, 1 was later excluded due to the intervention not aimed primarily at elder abuse. In total only 3

articles were identified as family-centered interventions aimed at primarily addressing elder abuse. The family-centered interventions were conducted in Israel, Iran and in the United States with the Native American community.

The results had been analyzed according to the RE-AIM framework. The RE-AIM framework assists to facilitate development, delivery and evaluation of health interventions according to five elements, namely, 1.) Reach – which refers to which target population will the intervention reach and was the intervention used on the intended target population, 2.) Effectiveness – refers to the intervention achieving its objectives/outcomes, 3.) Adoption – refers to target staff or organization adopting the intervention, 4.) Implementation – refers to consistency and adaption of intervention protocol to practice, 5.) Maintenance – refers to intervention effects on participants over time (Matthews et al. 2014). These RE-AIM elements will not only highlight vital aspects of the intervention but allow for comparison. These interventions will be looked at individually and later coalesced to educe trends within family-centered interventions directed at elder abuse.

Israel

A multi systemic approach had been used with services provided to victim, perpetrator, and family as well as community awareness as described by Lowenstein and Naim (2015).

Reach

The initiative is aimed at the elderly and their families (these include victim, perpetrator and their families), with the participants choice to include community members as well. No specific age criteria had been given but abuse would have had to have been identified by the interdisciplinary violence committees established in hospitals. These cases are then linked to support in the clients respective communities for continuity of care.

Effectiveness

Efficacy of the intervention is not explored as the article only described the intervention and had not carried it out with a specific group. Therefore, limitations, attrition and specific outcomes had not been reported.

Adoption

The intervention was inspired by a national initiative instituted by the Israeli ministry of health for professionals within the health system to identify, report, and provide recommendations for elder abuse of which continuity of care needs to be established with relative community services. The intervention which is a multi-systemic model had been created by the Unit for Services for the Elderly within the Ministry of Welfare, the National Insurance Institute and the Association for Planning and Development of Services for Aged in Israel. The setting in which the model is described is in the cities of Afula, Nazareth and Yezreel Valley, which contain municipalities which have Violence Prevention Units which implement the model. Those that facilitate the program as well as create each program include social workers, legal advisors, geriatrists and psychiatrists.

Implementation

The process begins with an elder abuse intake team which consists of an internal consultation team of the community and welfare unit in the regional council and not only acted as the diagnostic tool but helped build a program for the various cases. The procedure in which this was to be conducted was dependant on the various regional councils. Yet the format would usually consist of the case being discussed with the multidisciplinary team in the presence of the family. The multidisciplinary team is an expanded team consisting of a legal advisor and geriatrist/psychiatrist. A choice is given to the family if they would like community members involved in the intervention or prefer anonymity by working solely with a social worker. The communities also had their support and resources bolstered through training courses offered on elder safety and welfare as well as have loneliness, violence and other age related issues reduced by means of 'settlement support programs'.

Maintenance

Follow-up had not been given as the article described the intervention model and not carried it out.

Iran

The intervention unpacked by Khanlary et al. (2016) is the family-based cognitive behavioral social work intervention.

Reach

The intervention targeted the elderly aged ≥60 years, who have experienced at least one form of abuse as measured according to the Domestic Elder Abuse Questionnaire (DEAQ) as well as their families. All potential participants should not have participated in any family or individual based intervention and both elders and family members would have to be willing to participate. Overall 30 participants and their families were enrolled with 3 families later excluded due to reasons undisclosed yet which contributed for participants not participating in more than two-thirds of the sessions. Of the participants, 85.2% were male, with 59.2% living with their families in households of 3–4 individuals. All participants reported at least one type of abuse with 77.8% reporting their children to be the main abusers.

Effectiveness

The aim of the study was to test how effective family-based cognitive behavioral social work would be in reducing elder abuse. The intervention had been reported to reduce all forms of elder abuse except for physical abuse. Limitations noted were a small sample size and lack of long-term follow-up (3–6 months).

Adoption

Recruitment was noted to take place in a social security retirement association within Karaj, Iran with an announcement distributed in the Social Security Pensioners Club in Karaj. However, it is not clear if these associations provided the setting for the intervention to be conducted. It is not explicitly

stated if the intervention is widely used already by organizations or state or who delivered or facilitated the program.

Implementation

The intervention was noted as a 5 session program. The program covered themes such as neglect and alternative behaviors, principles of elderly care giving, and principles and techniques of conflict resolution. Techniques used was ice-breakers (first sessions), cognitive restructuring, modeling and role playing, guided discovery and brainstorming. Homework assignments were given at the end of each session, with these assignments reviewed at the start of the next session. Facilitators for the program had not been stated.

Maintenance

A 30 day follow up was done where 5 participants were evaluated on the DEAQ which used variables highlighting the different forms of elder abuse such as emotional neglect, care neglect, financial neglect, curtailment of personal autonomy, psychological abuse, physical abuse and financial abuse. No long term follow up had been conducted (3, 6 or 12 months post-intervention). The intervention reduced all forms of abuse except for physical abuse which showed no significant difference before and after the intervention.

United States

The Family Conference Care (FCC) as accounted by Holkup et al. (2007), is an elder-focused, family-centered, community-based intervention which involves family members, family-nominated supportive community members, spiritual leaders if desired, and the relative social service provider.

Reach

The Family Care Conference (FCC) was aimed at Native American families living on the reservations experiencing elder mistreatment. It targets the elders who have been mistreated, their family, but also includes family-nominated supportive community members, spiritual leader if desired as well as related health and service providers. Initially 26 families were referred for the intervention, with 3 families excluded due to high risk, 12 families deferred or resolved their issues another way. Ultimately 10 families participated.

Effectiveness

Whether the 10 families who participated reached resolution is not directly unpacked but is described in having followed through with the meetings. Only 1 family is noted pending outcome. Limitations are not addressed.

Adoption

The FCC used in this study is an adapted version initially created by the Maori people in New Zealand to address child welfare in a way that would not undermine families and traditional

values. The FCC had been an elder well-being and safety 5-year community-based participatory research project started by The Caring for Native American Elders Project. The FCC has now been adopted by the Community Health Representative Program, a program which has an established relationship with the reservation community, who will run it as a community-based project with the research team providing technical assistance. The FCC had hired and trained 3 tribal women from the reservation to serve as facilitators. The facilitators had a long history as tribe members, and not only understood the communities norms, family variations of assimilation and traditionalism but the facilitators were also respected by the communities on the reservation.

Implementation

The FCC consists of 6 stages. Stage one are the referrals obtained from elder protection programs, community health representative programs, the housing authority, domestic violence programs, tribal court, child protection as well as from the community and concerned family members. The second stage is the screening of the families with families with a high potential of violence excluded and immediately referred to the Elder Protection program for further evaluation and assessment. The third stage relates to engaging with the family. This entails establishing a primary contact in order to invite the family. Once the family is to together, the opportunity is taken to engage as to why some family members were not asked to attend which may make present members reconsider those who attend the conference. During this stage the facilitator notifies those in attendance the purpose of the gathering is address the concern of elder-well-being and safety but also address concerns the family members may have. This in turn requires communications skills which are non-judgmental and therapeutic in nature as a multitude of feelings such as resentment, grief, stress, shame and anger may have to be discussed in order for family members to commit to the family conference. This is preferably done face to face but distant relatives can be allowed to engage via conference phone call. Stage four deals with the logistical preparation for the family conference. Once all the nominated family and community members as well as service providers have been contacted, an agreeable meeting time is arranged. The facilitator sends out a letter to the prospective participants summarizing the purpose of the meeting and stipulating the date, time and venue. The day prior to the meeting, the facilitator called all family members who could be reached by phone. The venue chosen needed to be carefully considered as some might prefer their homes and others a more neutral place such as a conference room. Gracious hospitality was a strong community norm so the facilitator prepared snacks in line with dietary requirements and allowing participants to take whatever was left home. The participants also need to be told to consider participation barriers such as arranging child care, transportation as well as joining via conference call. These are all important to consider as the length of conference may be 2–5 h long.

The fifth stage is the family meeting. The beginning of the meeting starts with a welcome to all attending and as the facilitator, to point out that it is an honor to participate in this process which is a sensitive as well as intimate issue. The spiritual adviser who may have been invited could open with prayer. The facilitator then engages the group to establish ground rules or group norms everyone will follow during session. These points are written on a flipchart and placed in a position for all to see. Following this is the information sharing section of the session. Here concerns are identified and letters of those family members who could not attend are read aloud. Points made within this session are written on a flipchart. The facilitator draws from these points and highlights strengths of the

family identified through this process of engagement. Following this the family engages in developing a plan. During this time the family has the option to ask all non-family members to leave the room in order to develop a plan. The family is reminded to nominate a scribe during this process to write down everything discussed. The facilitator checks on the family periodically to clarify any questions they may have. Once the plan has been developed, the facilitator and service providers return to the room to assist in logistics needed to implement the plan of action such as assist in i) Identifying resources, ii) establishing timelines and iii) designating respective responsibilities to family members.

The plan is recorded and sent in a letter to family members the following week. The family also indicates when they would like the follow up meeting to occur. The closing of the family meeting allows the participants to evaluate what they liked about the process and what could have been done differently. This also allows for debriefing to take place.

The sixth stage of this process is the follow up meeting. This allows for the family to meet with service providers (maybe housing is needed for the elderly member while the caregiver or identified family member requires rehab). Also the family may discuss how the plan is working, maybe certain requests need to be modified or they decide to hold a second family conference for issues which may have deliberately been kept closed but now needs to be addressed.

Maintenance

Not clearly reported.

Coalesced Results and Noted Trends

Each study was evaluated according to the RE-AIM framework with results broken down into these elements for a holistic comparison. This framework structure allows us to collate the findings in a holistic manner to obtain process data and programmatic content.

Reach

All elderly participants had experienced at least one form of abuse or mistreatment as identified by the Domestic Elder Abuse Questionnaire (DEAQ) (Khanlary et al. 2016) or have mistreatment identified and reported by mental health or medical practitioners (Lowenstein and Naim 2015; Holkup et al. 2007). Inclusion criteria were that the elderly and their family members are willing to participate in the process as stated in all the studies reviewed, yet only one study stated an exclusion criterion whereby the elderly and their families should not have previously been in any other elder abuse interventions (Khanlary et al. 2016). Only one of the reviewed studies provided participant demographics which stated the age of elderly participants to be ≥60 years, most of the participants were male, and who stayed with their families in households of 3–4 people (Khanlary et al. 2016). Of the participants, 77.8% reported their children to be the main abusers (Khanlary et al. 2016). In two of the three reviewed studies, community members who are close to the family or who play a family-like role to the participant families, were also invited to participate (Holkup et al. 2007; Lowenstein and Naim 2015) as well as a spiritual advisor could be invited to the process if desired (Holkup et al. 2007).

Efficacy

Only one of the reviewed studies provided specific outcomes, which showed a reduction in all forms of abuse except physical abuse (Khanlary et al. 2016). The remaining two interventions reviewed, had not specified specific outcomes as the articles had only described the multi-systemic model of intervention for elder abuse (Lowenstein and Naim 2015) and the other which only reported the number of families which had participated and followed through with the intervention (Holkup et al. 2007).

Adoption

In terms of participant recruitment, community-based organizations (Khanlary et al. 2016; Holkup et al. 2007) as well health care facilities (Lowenstein and Naim 2015) acted as referrals to the various programs. One of the two reviewed studies described the intervention as being part of a national mandate to identify, report, and provide recommendations for elder abuse of which continuity of care needed to be established with relative community services which referred participants to community-based facilities, which had used social workers, legal advisors, geriatrists and psychiatrists as program developers and case facilitators (Lowenstein and Naim 2015). The other study stated the intervention was part of a 5 year community-based participatory research project by the Caring for the Native American Elders Project (Holkup et al. 2007). The intervention was then adopted by the Health Representative Program, an organization which had an established relationship with the participant community, with the original project team providing technical assistance (Holkup et al. 2007). Facilitators for the sessions, were three well respected tribal women known to the community and who were familiar with the community norms and traditions (Holkup et al. 2007).

Implementation

Two of the reviewed interventions described their programs consisting of 5–6 stages although frequency of sessions were not reported within the article (such as sessions per week) (Holkup et al. 2007; Khanlary et al. 2016). The third intervention only stated they had implemented a multi-systemic model created by the Unit for Services for the Elderly which was formed through various national agencies, with family interventions created on a case by case basis (Lowenstein and Naim 2015). The implementation process had been stipulated in only one study which included referrals, screenings, and family engagements to commit to the process, logistical preparation, the family conference and a follow-up session, with the family conference session described as being 2–5 h in duration (Holkup et al. 2007). Themes of the elder abuse intervention were only described in one study, and ranged from neglect and alternative behavior, principles of elderly care giving, as well as principles and techniques of conflict resolution (Khanlary et al. 2016). Techniques used were ice breakers, cognitive restructuring, modeling and role playing, guided discovery and brainstorming (Khanlary et al. 2016). Homework assignments had also been included (Khanlary et al. 2016). Only two of the three interventions state who delivers the intervention which are either facilitators recruited from within the community and trained for the intervention (Holkup et al. 2007) or using service providers from within the health and welfare system to formulate and carry out the intervention programs (Lowenstein and Naim 2015).

Maintenance

Only one of the reviewed interventions implemented a follow-up of 30 days post intervention of which the dimensions of the Domestic Elder Abuse Questionnaire (DEAQ) was used to assess progress (Khanlary et al. 2016).

Discussion

This review provides insight into how elder abuse had been addressed through family-centered approaches in order to create a comprehensive response. The RE-AIM framework allowed for not only a core comparison of the interventions to occur, but ease in collating the interventions core components. This comparison elicited trends within these interventions which brought forth key factors. These factors are namely the role of community and culture and how this may shape how we define elder abuse and effectively respond to it.

Two of the three interventions had brought through strong community ties as well as cultural undertones (Holkup et al. 2007; Lowenstein and Naim 2015), which is very important. Community and culture are factors which fall within a spectrum of understudied groups within family violence (Barnett et al. 2011). Community and culture needs to be explored to create an adequate response through cultural competence within family violence practice and research (Barnett et al. 2011). This ties in adequately in addressing elder abuse, as the elderly are noted in valuing social connections and family ties (Grundy 2006; Lowenstein et al. 2007). With culture at times dictating these social connections and family ties, as seen with Chinese and Latino elders (Tam and Neysmith 2006; Parra-Cardona et al. 2007).

Most of the interventions reviewed were community-based and in the case of the Family Care Conference (FCC) intervention, was later adopted by another community-based organization who received technical assistance from the original research team (Holkup et al. 2007). Community-based teams as seen in the Holkup et al. (2007) study, receiving technical assistance from the original research/project team is noted to have a bolstering effect on interventions as it contributes to high attendance rates (Spoth et al. 2007).

The interventions reviewed in this study were largely based in the Middle East and the Native American community in the US and do not ascribe to western thinking around dealing with family violence, as explicitly pointed out in the study using the FCC (Holkup et al. 2007). The interventions in these reviewed studies were community orientated with families being the cornerstone of community norms and traditions. For this reason elder abuse cannot be decontexualized, as traditional values and norms played an important role, as seen in 2 of the 3 interventions reviewed (Holkup et al. 2007; Lowenstein and Naim 2015). These traditions and norms may impact on the way abuse is defined, the context within which it exists and how elder abuse is addressed. This is seen the case of Chinese and Mexican immigrants.

A study focused on elder abuse amongst Chinese immigrants settled in Canada (Tam and Neysmith 2006) showed that the very perception of abuse differs from western norms. This phenomenon was also seen amongst Latino immigrants settled in the United States (Parra-Cardona et al. 2007). The perceptions of abuse amongst the Chinese were shown to have a strong basis in violating cultural norms and values. These forms of abuse identified by Tam and Neysmith (2006) included violating i) care respect - which would be seeing to the needs of the elderly but not being emotionally present, ii) victual respect - which means having specially requested food and drink (maybe due to health related dietary requirements) but

having it denied, iii) linguistic respect - such as name-calling and rudeness, and lastly, iv) special respect - which refers to providing adequate living quarters yet restricting the elderly and their movements. These acts may not seem overtly abusive within western society but are seen as blatant for example amongst the Chinese (Tam and Neysmith 2006). Elderly immigrants and elders caught up in cross cultural abuse are additionally reluctant to report abuse as stated earlier; their first instinct is to protect the family, which also includes their recognition of institutionalized racism, which is reflected through them and their ethnicity, by being marginalized within the labor market (Kwiatkowski 2015; Tam and Neysmith 2006). This adds to the fear of being a burden on their family, a fear found cross-culturally (Tam and Neysmith 2006; Barnett et al. 2011). This is important to note as the themes covered in the interventions reviewed related to conflict management and principles in taking care of the elderly. Furthermore we need to be sensitive as to what constitutes or denotes care giving and what is seen as abuse in order for any intervention not only to be needs sensitive but culturally competent.

By its very nature a family focused intervention is proven to be culturally inclusive and to show long term-results around ethnicities noted to be group-centered, as they would usually turn to family or community when in need (Gillum 2008; Spoth et al. 2007; Sumter 2006). This group-centered characteristic was noted in all 3 interventions yet was explicitly catered for in 2 of the 3 interventions which invited community participation (Holkup et al. 2007; Lowenstein and Naim 2015).

The content of the family centered interventions show a blend of what is traditionally done within elder abuse but also introduces the collaborative element of a family centered intervention, of using family caregivers as part of the solution in an attempt to sensitize them to the principles of elder well-being. These differences can be seen whereby all the programs presented in the paper did awareness raising, knowledge sharing and action planning with all concerned family members, which is in contrast to what has been done in European and Western interventions.

European and Western reactions, which are directed towards the elderly victim primarily, focus on knowledge and rights awareness in terms of prosecution, to bolster assertiveness, to create public awareness, extensively bolster and support social services and health care, and to provide support to caregivers (Zych 2015; Jagielska et al. 2015; Daly et al. 2011).

These foci may be helpful in extreme cases of elder abuse or in terms prevention, but when treating elder abuse, it may aggravate the fears of the elderly. Fears such as forced removal and institutionalization resulting in secondary trauma (Parra-Cardona et al. 2007; Ploeg et al. 2009), fear of revenge, blame or potentially breaking up the family if they report elder abuse (Prokop 2015). These fears are not far from reality as reported by Gair (2015) who found that the legal system was used against the elderly, in the form of protection orders and denied/disrupted visitation of their grandchildren, due to their reporting of family violence and neglect. The elderly were even viewed by certain authorities as 'meddlesome' or interfering when reporting child abuse and neglect of their grandchildren (Gair 2015).

The limitations of the current study can evidently be seen in the fact that the studies presented took place in communities that had strong ties and influence on the family. Thus it would not be sufficient to say if family centered interventions would have the same effect within European or Western societies as the dominant response is individualized and largely institutionalized when it comes to treating elder abuse. Additionally maintenance had not been reported for most of the interventions except one intervention, which had a 30 day follow-up but noted a long-term follow up was needed (Khanlary et al. 2016). This is important as long-term follow-up is needed in

order to establish long-term sustainability of behavior change and to assess which approaches offer the best chance of success (Jones et al. 2011). Also, only 3 studies were found to be family-centered in addressing elder abuse which makes generalizing the results and creating conclusive inferences challenging. Further recommendations for future research would be to explore family centered interventions within developed countries, which may improve the prevalence of elder abuse, if used as an alternative to what is currently being done.

Conclusion

Family centered interventions have been shown to decrease elder abuse due to its multisystemic approach in treating elder abuse in a holistic manner and incorporating factors which largely affect elder abuse. The aim of this paper was to offer family centered interventions to address elder abuse, by recognizing the elderly as important members not only within our communities, but families. Furthermore it is hoped that through this family centered approach, we can negate fear in speaking up about elder abuse and promote elder well-being within the family and community.

Acknowledgements The authors would like to acknowledge the South African National Research Foundation (NRF) (Grant no. 95015), for their partial funding contribution towards the PhD this article is part of.

Compliance with Ethical Standards

Conflict of Interest The authors declare no conflict of interest.

References

Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). *Family violence across the lifespan: An introduction*. Thousand Oaks: Sage Publications.

Berkamn, B. (2006). *Handbook of social work in health and ageing*. Oxford: Oxford University Press.

Bookman, A., & Kimbrel, D. (2011). Families and elder care in the twenty-first century. *The Future of Children, 21*, 117–140.

Burns, C. E., Dunn, A. M., Brady, M. A., Starr, N. B., & Blesser, C. G. (2008). *Pediatric primary care* (4th ed.). Missouri: Elsevier Health Science.

Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing, 37*, 151–160.

Daly, J. M., Merchant, M. L., & Jogerst, G. J. (2011). Elder abuse research: A systematic review. *Journal of Elder Abuse & Neglect, 23*, 348–365.

Erlingsson, C. L. (2007). Searching for elder abuse: A systematic review of database citations. *Journal of Elder Abuse & Neglect, 19*, 59–78.

Ferreira, M., & Lindgren, P. (2008). Elder abuse and neglect in South Africa: A case of marginalization, disrespect, exploitation and violence. *Journal of Elder Abuse & Neglect, 20*, 91–107.

Gair, S. (2015). Disputed and denied contact with grandchildren: 'I think it's a form of abuse. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 93–106). Toronto: European Association of Schools of Social Work.

Gillum, T. L. (2008). The benefits of a culturally specific intimate partner violence intervention for African American survivors. *Violence Against Women, 14*, 917–943.

Grundy, E. (2006). Ageing and vulnerable elderly people: European perspectives. *Ageing and Society, 26*, 105–134.

Holkup, P. A., Salois, E. M., Tripp-Reimer, T., & Weinert, C. (2007). Drawing on wisdom from the past: An elder abuse intervention with tribal communities. *The Gerontologist, 47*, 248–254.

Jagielska, K., Łukasik, J. M., & Pikuła, N. G. (2015). Elder abuse in the EU: Challenges for Poland. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 279–294). Toronto: European Association of Schools of Social Work.

Jones, R. A., Sinn, N., Campbell, K. J., Hesketh, K., Denney-Wilson, E., Morgan, P. J., Lubans, D. R., & Magarey, A. (2011). The importance of long-term follow-up in child and adolescent obesity prevention interventions. *International Journal of Pediatric Obesity, 6*, 178–181.

Khanlary, Z., Maarefvand, M., Biglarian, A., & Heravi-Karimooi, M. (2016). The effect of a family-based intervention with a cognitive-behavioral approach on elder abuse. *Journal of Elder Abuse & Neglect, 28*, 114–126.

Kwiatkowski, S. M. (2015). Role of research on elder abuse: Introducing main issues. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 9–16). Toronto: European Association of Schools of Social Work.

Lowenstein, A., & Naim, S. (2015). Means of prevention of elder abuse: The Israeli experience. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 177–192). Toronto: European Association of Schools of Social Work.

Lowenstein, A., Katz, R., & Gur-Yaish, N. (2007). Reciprocity in parent–child exchange and life satisfaction among the elderly: A cross-National Perspective. *Journal of Social Issues, 63*, 865–883.

Matthews, L., Kirk, A., MacMillan, F., & Mutrie, N. (2014). Can physical activity interventions for adults with type 2 diabetes be translated into practice settings? A systematic review using the RE-AIM framework. *Translational Behavioral Medicine, 4*, 60–78.

Parra-Cardona, J. R., Meyer, E., Schiamberg, L., & Post, L. (2007). Elder abuse and neglect in Latino families: An ecological and culturally relevant theoretical framework for clinical practice. *Family Process, 46*, 451–470.

Pillemer, K. A., Mueller-Johnson, K. U., Mock, S. E., Suitor, J. J., & Lachs, M. S. (2007). Interventions to prevent elder maltreatment. In L. S. Doll, S. E. Bonzo, D. A. Sleet, J. A. Mercy, & E. N. Haas (Eds.), *Handbook of injury and violence prevention* (pp. 241–256). New York: Springer.

Ploeg, J., Fear, J., Hutchison, B., MacMillan, H., & Bolan, G. (2009). A systematic review of interventions for elder abuse. *Journal of Elder Abuse & Neglect, 21*, 187–210.

Prokop, J. (2015). Home violence to seniors in the Czech Republic. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 227–242). Toronto: European Association of Schools of Social Work.

Sethi, D., Wood, S., Mitis, F., Bellis, M., Penhale, B., Marmolejo, I.I., Lowenstein, A., Manthorpe, G. & Kärki, F.U. (2011). European report on preventing elder maltreatment. World Health Organization.

Soares, J. J. F., Barros, H., Torres-Gonzales, F., Ioannidi-Kapolou, E., Lamura, G., Lindert, J., de Dios Luna, J., Macassa, G., Melchiorre, M. G., & Stankūnas, M. (2010). *Abuse and health in Europe*. Kaunas: Lithuanian University of Health Sciences Press b84.

Spoth, R., Clair, S., Greenberg, M., Redmond, C., & Shin, C. (2007). Toward dissemination of evidence-based family interventions: Maintenance of community-based partnership recruitment results and associated factors. *Journal of Family Psychology, 21*, 137–146.

Sumter, M. (2006). Domestic violence and diversity: A call for multicultural services. *Journal of Health and Human Services Administration, 29*, 173–190.

Tam, S., & Neysmith, S. (2006). Disrespect and isolation: Elder abuse in Chinese communities. *Canadian Journal on Aging/La Revue canadienne du vieillissement, 25*, 141–151.

Tolan, P., Gorman-Smith, D., & Henry, D. (2006). Family violence. *Annual Review of Psychology, 57*, 557–583.

World Health Organization. (2002). *World report on violence and health*. Geneva: World Health Organization.

Zych, A. A. (2015). Model solutions for counteracting violence against the elderly. In K. Jagielska, J. M. Łukasik, & N. G. Pikuła (Eds.), *Violence against the elderly: Challenges – Research – Action* (pp. 227–242). Toronto: European Association of Schools of Social Work.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.