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PROTECT: A Pilot Program to Integrate Mental Health Treatment Into Elder Abuse Services for Older Women

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Abstract

The goal of this pilot program was to test the usefulness of adapted Problem-Solving Therapy (PST) and anxiety management, called PROTECT, integrated into elder abuse services to reduce depression and improve self-efficacy. Depressed women victims were randomized to receive elder abuse resolution services combined with either PROTECT or a mental health referral. At follow-up, the PROTECT group showed greater reduction in depressive symptoms and endorsed greater improved self-efficacy in problem-solving when compared to those in the Referral condition. These preliminary findings support the potential usefulness of PROTECT to alleviate depressive symptoms and enhance personal resources among abused older women.

Keywords

depression; elder abuse; interdisciplinary practice; mental health; women

Elder abuse is an issue located at the intersection of age and gender. There is emerging evidence of high rates of depression among elder abuse victims, with almost one in three victims reporting significant depressive symptoms (Sirey et al., 2015), and older women victims are particularly at risk. To improve resilience and well-being, and address depression and anxiety among elder abuse victims, a brief evidence-based Problem-Solving Therapy (PROTECT) was developed. Preliminary data is presented here on the impact of the PROTECT intervention integrated into a routine elder abuse resolution service that offers aid to victims cognitively capable of taking self-protective measures. The goal of the intervention is to reduce depressive symptoms among abuse victims, improve their satisfaction with services, and increase feelings of self-efficacy in problem-solving. This

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combination of abuse resolution services and concurrent psychotherapy is hypothesized to promote resilience among older women being mistreated.

Background

Elder abuse is a widespread and growing problem, currently affecting an estimated 3 to 4 million older adults in the United States each year (Taylor, 2014) and 2–14% of adults surveyed in international samples (Daly, Merchant, & Jogerst, 2011). Although older men and women both fall victim to mistreatment, current research suggests that rates of elder abuse are higher among women (Connolly, Brandl, & Breckman, 2014; Lachs & Berman, 2011; Raymond, Brandl, & Bosch, 2008). Research by Mouton et al. (2004) has found that older women are more likely than men to suffer most forms of elder abuse even controlling for differences in lifespan. In practice, of the 28 states that use a formal risk assessment when assessing Adult Protective Services (APS) clients, 22 include gender as a significant risk factor for abuse (Goodrich, 1997).

To date, much of the domestic abuse literature here and abroad has focused on violence against younger women (Fisher & Regan, 2006); however, even among nondependent (self-sufficient) older adults, physical and verbal abuse occur at equal or higher rates for elderly women compared to their younger counterparts (Mellor & Brownell, 2013; Mouton et al., 2004). Older women are significantly less likely than younger victims to report domestic or family abuse to the police (Fulmer, Guadagno, & Bolton, 2004) and may face stronger barriers to seeking and receiving help, due to limited mobility, poor physical health, and often feelings of resignation in response to longstanding abuse (Brownell & Heiser, 2006; U.N, 2013). Among elderly victims, the perpetrator is more likely to be one of the only close relationships the victim still has, increasing her reluctance to take self-protective action (Brownell, 1996; Zink, Regan, Jacobson, & Pabst, 2003). Moreover, victims' own adult children are the most typical elder abusers in many countries, further deterring older women from taking legal action against their abusers (Chokkanathan & Lee, 2006; Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997; Naughton et al., 2011). In some cases, the victim even serves as a caretaker for the abusive child, creating a strong internal conflict between the urge to be a "good mother" and the need to protect oneself from mistreatment (Brownell & Heiser, 2006).

Existing programs that could offer assistance rarely have resources or services tailored to the unique needs of older women (Brandl, Hebert, Rozwadowski, & Spangler, 2003; Brownell, Berman, & Cox, 2000). Few elder service agencies in the United States offer interventions for abuse victims, while most domestic abuse agencies target women between the ages of 20 and 40 years old (Raymond et al., 2008). In addition, community research indicates that few older women are aware of *any* programs available to victims of elder abuse (Moon & Evans-Campbell, 2000). With the ongoing lack of abuse services designed specifically for older adults, there is limited outcome data on the effectiveness of those existing abuse services and programs (Straka & Montminy, 2006). At present, many elder abuse interventions take place through APS, which has limited funding, requires substantial cognitive impairment for client eligibility, and is ill-equipped to address issues such as concurrent clinical depression (Brownell, 1996; Dong & Simon, 2011; Quinn & Tomita, 1997).

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Depression is a significant global health issue strongly associated with elder abuse. One recent study of elder abuse victims found that 34% screened positive for clinically significant depression on a standardized screening tool (Sirey et al., 2015), roughly twice the average rate documented for community-dwelling adults (Luppa et al., 2012). Moreover, depression is both a risk factor for and consequence of abuse. Depression results in persistent feelings of guilt and hopelessness that likely undermine victims' motivation to resolve the abuse, and may further increase their reluctance to disclose the mistreatment to others who could help (Sirey et al., 2015; Tamutiene et al., 2013). Executive functioning and decision making are often impaired or distorted in depressed older adults, again reducing the likelihood that these abuse victims will take self-protective measures (Dyer, Pavlik, Murphy, & Hyman, 2000).

Over the course of their lifetimes, nearly 30% of women in the United States will experience some form of depression (Kessler, 2000). Among abused older women, depression likely reduces the will and energy to seek help and exacerbates the tension between taking self-protective measures and supporting an abusive child. The depressed older victim may not perceive a sense of control or self-efficacy, or possess the problem-solving skills necessary to implement protections. Given the complexity of the abusive situation, there remains a clear need for collaborative programs beyond those offered by APS and systematic research on the development, implementation, and outcomes of elder abuse interventions (Lachs & Berman, 2011; Wallace & Bonnie, 2003).

The purpose of this pilot study was to examine the preliminary effectiveness of PROTECT, a form of Problem-Solving Therapy (PST) adapted specifically for victims suffering from depression to reduce their symptoms. Given the importance of improving victims' self-esteem and empowerment (Brownell & Heiser, 2006), secondary aims were to increase victims' self-efficacy in problem solving and potentially to improve perceived elder abuse outcomes. Feasibility data regarding the intervention and its protocol have previously demonstrated the acceptability of PROTECT in this population (Sirey et al., 2015). We hypothesized that older women who participated in our program would demonstrate greater improvements in depressive symptoms compared to those in the Referral control condition. In addition, we hypothesized that there would be greater satisfaction with offered elder abuse services, higher self-efficacy in problem-solving, and ultimately, greater resolution of the mistreatment.

To our knowledge this is the first randomized controlled trial to evaluate a mental health intervention for abused older women with concurrent mental health needs. One of the major barriers to conducting research with this population is a lack of collaboration between different aging service networks that can provide specialized and complementary resources (Brownell, Welty, & Brennan, 2005; Fulmer et al., 2004; Wallace & Bonnie, 2003). For this project Weill Cornell Medical College partnered with New York City's Department for the Aging (DFTA), the largest Area Agency on Aging in the country, and their Elderly Crime Victims Resource Center (ECVRC) to ensure an interdisciplinary approach to the treatment of abused older women.

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METHOD

Overview

This pilot program was designed to examine the preliminary impact of integrating a brief psychotherapy into a routine New York City elder abuse service. Within DFTA, the ECVRC provides face-to-face and phone-delivered abuse resolution assistance to older adults who are capable of taking self-protective measures. This program was conducted with academic consultants to aid in the design and delivery of the psychotherapy as well as analysis of the deidentified data. Academic and community partnerships built to develop and implement interventions like this one increase the likelihood that the program will be supported and sustained by community partners (Wells, Miranda, Bruce, Alegria, & Wallerstein, 2004). The PROTECT study is currently registered with ClinicalTrials.gov, number NCT02283385.

In this pilot project, all services were provided and data was collected by the elder abuse service and stored in their existing database system. The data review and analyses were approved by the Weill Cornell Institutional Review Board to utilize coded and deidentified data provided by ECVRC and DFTA (IRB 1301013434). Cornell staff time was supported by funding from the Weill Cornell Institute of Geriatric Psychiatry Advanced Center for Intervention and Services Research (NIMH P30 MH085943).

Participants

Participants were older women (age 60) receiving services from DFTA's ECVRC who screened positive for depression on the Patient Health Questionnaire-9 (PHQ-9), a well-validated and highly reliable measure of depressive symptoms (Lowe, Unutzer, Callahan, Perkins, & Kroenke, 2004). Clients were also screened for anxiety using the Generalized Anxiety Disorder-7 (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006). Weill Cornell faculty taught ECVRC social workers to screen for depression and anxiety using these standardized tools, and ECVRC has subsequently been screening for mental health services since 2012 (Sirey et al., 2015). Exclusion criteria included current psychosis or substance abuse, bipolar disorder, significant cognitive impairment (as determined by the ECVRC social worker), or an inability to communicate in English.

Recruitment

For those clients whose screenings indicated clinically significant depression or anxiety (PHQ-9 or GAD-7 10, respectively), the ECVRC social worker briefly described the option to include mental health treatment with elder abuse services. For each client, ECVRC staff made clear that accepting mental health services was both voluntary and independent of their receiving standard elder abuse resolution services.

Randomization

Clients who accepted the program were randomized to receive either abuse resolution services and a community mental health referral, or abuse resolution services combined with the PROTECT psychotherapy. Referral clients were offered a mental health referral for services that (a) were available in the client's local community and (b) accepted the client's insurance. In addition to mental health assistance, all women received abuse resolution

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services from DFTA's ECVRC; typical services include case management, seeking orders of protection, developing safety plans, and guidance throughout the legal process. Study randomization was implemented and recorded by the ECVRC director, who tracked all participating clients. No overrides were permitted for random assignment.

Roughly 4 months after acceptance into the program, clients were contacted via telephone by an independent DFTA staff person for a brief follow-up telephone interview. The follow-up interview was conducted to assess depressive symptoms, client satisfaction with services, and perceived self-efficacy in problem solving. All clients were offered a $25 gift card as modest compensation for their time during the follow-up interview. This reinterview strategy has been used previously by DFTA to evaluate the outcomes of their interventions (Berman & Furst, 2011, 2014). All interviewers were kept blind to participants' group membership to minimize bias.

Intervention

PROTECT stands for PRoviding Options To Elderly Clients Together. The PROTECT intervention combines PST with anxiety management techniques and offers education about the impact of depressive and anxious symptoms in general, as well as the potential impact of symptoms on taking steps to resolve the mistreatment. The details and feasibility of this version of PST have been described in a previous manuscript (Sirey et al., 2015). PST was chosen because it is an empirically validated, brief psychotherapy with demonstrated efficacy in reducing significant depressive symptoms among older adults (Alexopoulos, Raue, & Areán, 2003; Areán et al., 1993; Areán et al., 2010). For this population, PST offers the flexibility to work synergistically with elder abuse resolution services and imparts problem-solving skills that target a broad range of problems, including those related to ongoing abuse. The PROTECT intervention uses evidence-based techniques that have been tailored to the population and vetted by our community partners.

PROTECT is delivered in eight sessions after a clinical evaluation, with at least the first session delivered face to face. Each subsequent session is conducted using problem-solving worksheets completed either in person or over the telephone. For this pilot program, flexibility in delivery format (in person or via telephone) was provided to take into account the potentially unstable living situations of the victims (who often lived with their abusers).

Outcomes

After initial randomization, all clients were recontacted to evaluate mental health and elder abuse outcomes. For those randomized to the Referral group, follow-up assessments were conducted 4 months from the date of the referral. Follow-up with PROTECT clients took place after all intervention sessions were completed. Those clients able to be interviewed were readministered the PHQ-9 to document changes in depressive symptoms after controlling for baseline symptom severity.

Elder abuse outcomes were measured subjectively in three ways, by assessing victims': (a) perceived change in level of abuse, (b) perceived self-efficacy in dealing with problems, and (c) satisfaction with the services received. To explore whether clients had perceived any change in their mistreatment status, they were asked a single-item question: "Would you say

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the level of mistreatment/abuse you are experiencing now is the same, better, or worse than before?" Clients were also asked to provide feedback about their satisfaction with services; they could endorse being "very satisfied, mostly satisfied, indifferent, mostly dissatisfied, or very dissatisfied." Finally, clients were asked how useful the services were in helping them "to deal more effectively with [their] problems." Clients could report that the program helped a lot, somewhat, or not at all.

Data Analysis

All data were collected by DFTA staff and entered into a DFTA database with the baseline screening data; a deidentified dataset was provided to Weill Cornell for further analysis. Descriptive analyses were conducted to determine the rate of clients who had clinically significant depressive symptoms as recorded on the PHQ-9. An independent-samples t-test was used to compare group changes in PHQ-9 scores (depression severity) over time, controlling for baseline depressive symptoms. Chi square analyses assessed changes in mistreatment status, client satisfaction with services, and clients' perceived self-efficacy in problem solving. All analyses were conducted using SPSS Version 22.

Case Example: Background

Ms. V is a 70-year-old married African American woman who lives in an apartment building in New York City. Her husband resides permanently in a nursing home due to complications from past substance abuse. She has five adult children, and four grandchildren currently living in foster care.

Ms. V did not report any abuse herself, but was originally referred to the ECVRC after her 19-year-old granddaughter deposited fraudulent checks in Ms. V's name. The granddaughter, who had been diagnosed with bipolar disorder, was verbally abusive, threatening, and refused to go to school. However, Ms. V reported feeling that she herself was preventing the growth of her children and grandchildren, worrying that "my being here is a crutch." She felt like a failure as a mother and was suffering from persistent feelings of hopelessness, guilt, fatigue, and low self-esteem. She reported a history of depression with one prior psychiatric hospitalization.

The initial focus of the PROTECT intervention was on setting boundaries for Ms. V's family, who relied heavily on her for emotional and financial support and often showed up at her home unannounced. Ms. V felt especially overwhelmed by the constant demands from these family members and the chaos they often brought to her home. In weekly therapy sessions, the PROTECT counselor encouraged her to set manageable goals to reduce their harmful behavior, such as limiting lengthy phone calls with a timer and refusing to be the "middleman" for other family members. Because Ms. V was limited in mobility, the PROTECT counselor met with her at a local senior center for their sessions. This arrangement had the added benefit of enabling Ms. V to renew her lapsed membership.

RESULTS

Of the 315 elder abuse victims screened by ECVRC staff over 1 year, 106 (34%) had clinically significant depression or anxiety and were recommended to receive a mental

health treatment in conjunction with elder abuse services. This is the highest rate of mental health needs reported by any aging service population in New York City. Only 16 victims (15%) refused to consider any mental health support. Twenty-one individuals were excluded for cognitive impairment, comorbid psychotic disorders, or current substance abuse. A total of 68 women were randomized to either the PROTECT or Referral condition for this pilot program. Full follow-up data were available for 45 clients. There were no significant differences with respect to age, treatment group, or initial depression severity between clients who completed the follow-up and those who refused or could not be contacted.

Participant Characteristics

Of the 68 elder abuse victims who participated in our program, the majority (81%) were living with their abuser at the time of the study. With regard to abuse type, 59 women (87%) reported emotional or psychological abuse; 25 (37%) reported financial abuse; and 18 (26%) reported physical abuse. Half of all victims (50%) were experiencing more than one form of mistreatment at the time of the study, with the most common combination being concurrent emotional and financial abuse (15/34; 44%).

The majority of women in this pilot program (92%) reported clinically significant depressive symptoms (PHQ-9 10) when assessed by ECVRC social workers at baseline, with an additional 5% endorsing a subthreshold score of 9. Only 2 individuals (3%) were included based on a GAD-7 score of 10 or greater. The mean PHQ-9 score for all clients was 14.0 (SD = 4.2), indicating moderate depression. There was no significant difference in baseline depression severity for Referral (M = 13.6, SD = 4.3) versus PROTECT clients (M = 14.4, SD = 4.3).

Depression Outcomes

An independent samples t-test was conducted to examine the potential impact of the PROTECT intervention on changes in depression over 16 weeks. At follow-up, Referral and PROTECT clients were equally likely to report improved symptoms as indicated by PHQ-9 scores < 10. However, PROTECT clients experienced a trend toward greater percent decreases in depressive symptoms by 16 weeks (57%) compared to those women who received a standard referral (37%), $t(44) = 1.765$, $p = .08$, Cohen's $d = 0.56$. Mean follow-up PHQ-9 scores were 7.9 (SD = 5.0) and 6.3 (SD = 5.7) for Referral and PROTECT clients, respectively.

Elder Abuse Outcomes

Compared to women in the Referral group, those in the PROTECT intervention were significantly more likely to report having "most or all" of their needs met (78% versus 35%) at the time of follow-up, $\chi^2 = 9.24$, df = 2, $p = .01$. Only a single victim in the PROTECT condition reported that "none" of her needs had been met; by contrast, over one-quarter (28%) of women who received only a referral (in addition to abuse resolution services) reported having none of their needs met. Those clients who stated that most or all of their needs had been met were also significantly more likely to report an improvement in abuse status, $\chi^2 = 7.40$, df = 2, $p = .03$. In addition, a significant group difference was found with regard to overall satisfaction, $\chi^2 = 10.32$, df = 2, $p = .02$. Nearly two thirds (65%) of women

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in the PROTECT group indicated that they were "very satisfied" with the program, whereas only 35% of Referral clients were satisfied overall with the services they received.

To capture a sense of self-efficacy regarding their abusive situation specifically, clients were asked if the services they received had helped them "to deal more effectively with [their] problems." Compared to victims in the Referral condition, PROTECT clients were significantly more likely to report increased feelings of efficacy in dealing with their problems at follow-up, $\chi^2 = 8.83$, df = 2, p = .01. Most PROTECT clients (65%) indicated that the intervention had helped them "a great deal" with problem solving, compared to 43% of women who received a standard referral. Only 2 PROTECT clients (7%) reported that the intervention did not help "at all," whereas nearly half of Referral clients (43%) said that they did not feel any greater self-efficacy in dealing with their problems at follow-up. In addition, women who endorsed dealing more effectively with their problems were significantly more likely to report concurrent improvement in abuse status at follow-up, X^2 (2, N = 45) = 10.81, p = .004.

Across all clients, 68% of women in the PROTECT group reported an improvement in perceived abuse status compared to 50% of those in the Referral group; however, the difference was not statistically significant in this sample.

Case Example: Outcome of PROTECT

Over the course of her sessions Ms. V successfully implemented small ground rules to limit the abusive behavior of her family members. After encouragement from the PROTECT counselor, Ms. V eventually told her granddaughter that she could no longer live with her. Ms. V began to resume activities that were enjoyable and meaningful to her, including yoga and meditation, Bible study, computer classes, and dancing when she could be home alone. As Ms. V regained her sense of self, she came to realize that she could not effectively support and gain custody of all four grandchildren living in foster care, given her own age and health issues. After previously agonizing over this big decision for a long time, Ms. V was now able to resolve this inner conflict with a sense of calm and clarity.

After receiving the PROTECT intervention, Ms. V reported feeling much better and more confident in solving her life's problems. She said she was no longer "going with the flow," but was paying attention to her own needs and making more time for herself. Ms. V was no longer racked with guilt over long-term obligations to her family, and realized that she too deserved to be happy: "I stick up for myself now. I've found my voice."

DISCUSSION

Findings from this pilot program support the potential effectiveness of the PROTECT intervention to reduce depressive symptoms and improve feelings of self-efficacy among older women being abused. There was a trend in the expected direction such that PROTECT clients experienced a greater decrease in depressive symptoms compared to victims who received a standard mental health referral. Women in the PROTECT group also reported significantly improved feelings of self-efficacy in problem solving, as illustrated in the case

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of Ms. V, and were more likely to report having “most or all” of their needs met at follow-up.

To our knowledge this is the first program to integrate evidence-based psychotherapy into elder abuse services designed specifically to address the needs of abused and depressed older women. Not only is depression significantly heightened among elder abuse victims (Lachs & Pillemer, 2004; Mellor & Brownell, 2013; Sirey et al., 2015), but it further increases victims’ risk of continued abuse by intensifying feelings of guilt and undermining motivation to start the difficult process of resolution (Roepke-Buehler, Simon, & Dong, 2015). Although the results were not statistically significant, our data suggest that the PROTECT intervention may mitigate some of the psychological factors hindering abused older women by helping to alleviate their depressive symptoms. Randomized treatment trials with older women with comorbid arthritis (Lin et al., 2003) and breast cancer (Antoni et al., 2001) have found that decreasing depression can lead to reduced functional impairment, improved emotional processing, and greater optimism among patients, outcomes that may all help to mobilize the abuse resolution process.

The greater perceived self-efficacy and its association with reported improvements in abuse status among women in the PROTECT group suggests a possible link between increased problem-solving skills, decreased depression, and potentially greater agency among abused older women. Research has clearly established the link between improved depression, greater self-efficacy, and behaviors that promote health and well-being among older adults (Blazer, 2002). Self-efficacy may reduce depression both directly and indirectly by enhancing social relationships (Saltzman & Holahan, 2002), increasing exercise and minimizing unhealthy behavior (Lachs & Pillemer, 2004), and encouraging a positive outlook on life (Blazer, 2002). This reciprocal relationship between self-efficacy and depression may be particularly important for fostering resilience among older women, who typically endorse lower self-efficacy (Rosenfield & Mouzon, 2013; Scholz, Doña, Sud, & Schwarzer, 2002) and greater rates of depression-related comorbidity compared to older men (Berman & Furst, 2011; Blazer, 2003). Given the deleterious effects of abuse on women’s self-esteem and sense of control (Brandl et al., 2003), improving self-efficacy may offer a strategy both to combat depressive symptoms and restore feelings of empowerment among abused older women.

Enhancing feelings of self-efficacy in problem solving may also be especially critical for encouraging older women to report abuse and take explicit steps to protect themselves from further mistreatment. Recent research suggests that abused older men may be more likely to report their mistreatment to the police, which in turn increases the likelihood of continued, self-protective behavior (Amendola, Slipka, Hamilton, & Whitman, 2010). Given the high rates of elder abuse by victims’ adult children (Lachs et al., 1997; Naughton et al., 2011), rigid cross-cultural stereotypes about motherhood and self-sacrifice for one’s child may provide an additional barrier to help seeking for older women. Enabling depressed victims to break these challenges into manageable steps may help them to tackle such stereotypes about maternal obligations that contribute to the cycle of abuse. Our findings demonstrate that the PROTECT intervention may alleviate older women’s depressive symptoms and

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increase feelings of self-efficacy related to problem solving, both of which are critical to fostering resilience among victims of elder abuse.

LIMITATIONS

While the pilot program to examine PROTECT provides encouraging results, there are limitations to both the project design and its findings. Designed as an academic-practice collaborative first-step test of PROTECT, this model limited our research assessment strategies. As an evaluation program, we were unable to measure factors such as social isolation, history of abuse/trauma, or prior mental health needs, all of which likely affect client outcomes. Moreover, single-item measures were chosen over longer, standardized scales such as the General Self-Efficacy Scale (Jerusalem & Schwarzer, 1979) to reduce client burden for a vulnerable population. As such, our client outcome data is based primarily on subjective appraisals. Our measures of elder abuse captured the victim's perspective, but we were unable to assess actual incidences of abuse or criminal justice outcomes. However, this was also due in part to the continued absence of systematic tools to detect and measure the occurrence of multiple forms of elder abuse (Imbody & Vandsburger, 2011).

The small sample size of this pilot program also limits the generalizability of our results to the greater population. In addition, our ability to explore any differences associated with race and ethnicity were limited by the ECVRC chart data. As a service often delivered via telephone, ECVRC staff do not routinely ask about ethnic or racial background.

Finally, our findings are limited by the inability to assess how many Referral clients actually received mental health treatment as well as the abuse resolution services offered to each client individually. ECVRC staff did not ask if clients had followed through with the Referral or sought additional mental health treatment in the preceding months; consequently, we cannot determine the average level of treatment received by older women in our control group. In the study we are currently conducting, we are collecting this important data on the rates of referral acceptance and type of mental health treatment received, as well as the specific social services offered to each ECVRC client.

Notwithstanding these limitations in the program design, the pilot implementation of PROTECT supports its potential usefulness as an intervention to improve mental health and abuse outcomes among older women experiencing various forms of abuse. The PROTECT intervention offers an integrated approach to the provision of mental health and abuse resolution services and provides a strategy to build problem-solving skills and self-efficacy among victims of mistreatment. Understanding the complexity of the abusive situation, this may be a small inroad to helping older women ultimately achieve abuse resolution and other desired outcomes: integrated psychotherapy may mitigate some of the psychological factors associated with abuse, such as hopelessness and self-blame, and motivate women to take self-protective steps. In addition, the project allows a heuristic approach to mental health care by implementing an intervention that is minimally burdensome yet still captures victims' individual preferences and perceptions. Future work is needed to test the efficacy of

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PROTECT in a randomized controlled treatment trial, including independent research assessments and objective mistreatment outcomes measured with greater precision.

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