



An under-recognized epidemic of **ELDER ABUSE** needs your awareness and action

Your preventive and protective efforts to combat this public health concern should be refined and redoubled

Kaleigh Hubert, BS, BA

Physician Assistant Student
Daemen College
Amherst, New York

Sanjay Gupta, MD

Consulting Psychiatrist
DENT Neurological Institute
Medical Director, Geriatric and Adult Psychiatry
Mid-Erie Clinic
Buffalo, New York
Clinical Professor
Department of Psychiatry
State University of New York at Buffalo
Buffalo, New York
State University of New York
Upstate Medical University
Syracuse, New York
Member, Editorial Board, *CURRENT PSYCHIATRY*

Disclosures

Ms. Hubert reports no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

Dr. Gupta is a member of the speakers' bureau of Alkermes, Allergan, Avanir Pharmaceuticals, Takeda Pharmaceutical, Lundbeck, Otsuka Pharmaceutical, and Sunovion Pharmaceuticals.

In its simplest form, elder abuse refers to the intentional infliction of injury or neglect of an older adult by a caregiver. The 5 primary types of elder abuse include neglect, physical, financial, psychological/emotional, and sexual, with a subtype of social abuse that falls under psychological/emotional abuse.

Differentiating abuse from the normal sequelae of physiologic aging can be difficult; therefore, early identification and awareness of risk factors is key, as well as detailed documentation of the patient encounter. As soon as abuse is suspected, clinicians should report it to Adult Protective Services (APS) for further investigation. In terms of prevention, regular screening for elder abuse is still up for debate, but as the incidence of elder abuse continues to rise so should research and preventive efforts to combat this growing public health concern.

What is 'elder abuse'?

According to the Elder Abuse Prevention, Identification, and Treatment Act of 1985, elder abuse is:

...willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness.¹

There are 2 main components to this definition:

- an older adult has suffered injury or deprivation
- another person is responsible for causing or failing to prevent it.²

continued



Elder abuse

Clinical Point

Maintain a high index of suspicion for financial exploitation when you note unexplained changes in power of attorney or a last will



Discuss this article at
[www.facebook.com/
CurrentPsychiatry](http://www.facebook.com/CurrentPsychiatry)

Although definitions vary, it generally is accepted that, for elder abuse to occur, it must take place within a relationship of trust.³

An 'older adult' is a person age ≥ 65 , representing 14% of the U.S. population.⁴ According to U.S. Census Bureau data, there were 40 million older adults in 2010⁵; recent data project that this number will rise to 90 million by 2060 as Baby Boomers age.⁶ Studies suggest that as many as 10% of older adults in the United States experience elder abuse each year²; one study estimated that 6% of older adults in the community experienced significant abuse in the past month.⁷

Although elder abuse can occur in any setting, it takes place most often in the community. A survey of state APSs in 2000 showed that 60.7% of abuse was domestic; only 8.3% of incidents occurred in institutional settings.⁸ The annual direct medical costs associated with elder abuse injury in the United States are estimated at \$5.3 billion, which is likely to increase with anticipated growth of the geriatric population.⁹

Although the number of older adults and the incidence of elder abuse are on the rise, as few as 1 in 14 cases is reported to authorities¹⁰; health care providers are some of the least likely of involved parties to report suspected abuse. One study found that 63% of physicians never asked about elder abuse, and only 31% reported encountering it in the previous 12 months.¹¹ A busy clinician—ie, one who sees 20 to 40 geriatric patients a day—has a high likelihood of encountering at least 1 victim of elder abuse,² yet many cases go unrecognized.

Types of abuse

Elder abuse comprises 5 categories¹²:

- neglect (58.5% of cases)
- physical (15.7%)
- financial (12.3%)
- psychological and emotional (7.3%)
- sexual (0.04%).

Social abuse is considered a subtype of psychological and emotional abuse. All "other" types of abuse constitute 5.1% cases; 0.06% are of unknown type.¹²

Neglect is (1) failure of the caregiver to provide life necessities or (2) the responsible person's refusal to permit others to provide appropriate care.³ This is one of the most common types of elder abuse in residential facilities. Signs of neglect include dehydration, depression, fecal impaction, and malnutrition (*Table, page 33*).⁴ The prevalence of dehydration in nursing home patients is reported to be as high as 35%, which may be the result of passive or active withholding of liquids (ie, decreasing hydration to reduce the need to change the resident's clothing or bedding).⁴ Other forms of neglect include medication misuse (overdosing or underdosing) and self-neglect, which occurs among people living alone and often is listed as a subtype of neglect, but is controversial because it does not involve another person.

Physical abuse is a non-accidental act that results in physical pain or injury,³ including bruises, fractures, and burns. Physical abuse is among the most common types of abuse in nursing homes; it has been suggested that approximately 4.8% of residents experience physical abuse that results in a police investigation.¹³

New research describes resident-on-resident abuse as one of the most prevalent causes of physical abuse.¹⁴ Dementia and cognitive decline complicate resident-on-resident abuse, particularly from the standpoint of treating aggression.

Financial exploitation is the illegal or improper use, or mismanagement, of a person's money, property, or financial resources³—often, to his (her) detriment. Estimates are that 1 of every 20 older adults has been subject to financial abuse at some point in their life.¹⁵ There should be a high index of suspicion for financial exploitation when one notices unexplained changes in power of attorney, wills, or other legal documents; missing checks, money, or belongings.¹⁶

In the past, adult children were most likely to be financial abusers; in recent years, however, the abuser is more often a spouse—especially a second spouse.¹⁷ Bankers, accountants, and other financial advisors are among those trained to identify risk factors

for financial abuse; they are encouraged to caution clients about this possibility.¹⁸

Psychological and emotional abuse occurs when a caregiver inflicts mental stress on an older adult by actions and threats that cause fear, violence, isolation, deprivation, or feelings of shame and powerlessness.³ Examples are threatening to put the older adult in a nursing home or verbally abusing him (her). Suspect this type of abuse when a caregiver refuses to leave the older adult or speaks for him, or if the older adult expresses fear in the presence of the caregiver.⁴ This type of abuse also is prevalent in nursing homes and other long-term care facilities.¹⁹

Sexual abuse involves nonconsensual touching or sexual activities (rape, language, exploitive behavior) that are threatened or forced on an older adult.¹⁶ Sexual abuse is more common in frail or dependent persons.³ Physical exam findings—particularly dysuria, tender genitalia, and evidence of sexually transmitted infections⁴—are required to identify sexual abuse, along with signs of depression and display of fear.

Social abuse can be considered a subtype of psychological and emotional abuse, in which a caregiver denies an older adult contact with family and friends or deprives him from access to transportation. Other examples include not allowing the older adult to use the telephone, monitoring phone calls, and claiming that his friends or family are “interfering.”²⁰ Intentionally embarrassing an older adult in front of others also can be considered social abuse.

Technology, particularly smart phones and social media, can complicate and exacerbate elder abuse:

- In July 2013, employees of a Wisconsin nursing home were found with videos and photographs of residents bathing and of a nude resident who had a bowel obstruction being mocked.²¹

- In May 2014, employees of a nursing home in Massachusetts recorded themselves physically and verbally abusing several older adults with Alzheimer’s disease, including one episode of the employees

“hitting the woman on her arms, flicking her ears and then pinching the woman’s nose closed.” The employees also possessed a photograph of her naked.²²

- In June 2015, an employee of a nursing home in Indiana was accused of taking photos of a resident naked and sharing them on the messaging application Snapchat,²³ in which images disappear 10 seconds after they are viewed.

As technology evolves, caregivers are finding more cunning ways to abuse older adults. Considering current events and trends in this area, technology as a gateway to elder abuse should be of growing concern.

Risk factors

A 2013 literature review on elder abuse reported that the most important risk factors are related to relationship (family disharmony, poor or conflicting relationships) and environment (a low level of social support),³ although other variables can play a role. Regardless of these findings, it is important to recognize that (1) elder abuse is not a necessary consequence in a family with many risk factors and (2) elder abuse can occur in the absence of any risk factors.

As a whole, women are at a higher risk of abuse, particularly when combined with loneliness, poor social support, cohabitation (especially family members), substance abuse, cognitive impairment, and dementia and other mental health problems.⁴ Other risk factors include functional deficiency, poor physical health or frailty, low income or wealth, and trauma or past abuse.³

Lower income, poor health, low social support, and belonging to a non-white racial group put an older adult at risk for neglect; female sex is a specific risk factor for sexual assault.¹⁵ One study found that, among older adults who suffered physical, mental, or cognitive impairment, 1 of every 4 was at risk of abuse.⁷

Mental illness. Dementia puts an older adult at higher risk because of increased caregiver stress resulting from disruptive and aggressive behaviors²; the same is true when the older adult suffers another mental illness, such as anxiety, depression, schizo-

Clinical Point

Women are at higher risk of abuse, particularly when combined with loneliness, poor social support, and cohabitation



Elder abuse

Clinical Point

Despite evolving attitudes, fear of homophobia still prevents some LGBT older adults from seeking help when abused

continued from page 25

phrenia, or bipolar disorder. Presumably, older adults with any of these disorders are at risk of financial and psychological and emotional abuse because of their decreased social support, lack of independence, and inability to hold a job—leaving their caregiver to shoulder more responsibilities and with more opportunities to inflict abuse. In addition, an older adult suffering from depression can feel helpless and unworthy, possibly making him more susceptible to psychological and emotional abuse, and less likely to seek help.

More research is needed to establish racial and ethnic differences in the risk of abuse. Some research states that older adults who are a member of a minority are at greater risk of abuse; however, the difference dissipates after adjusting for variables such as income and social support.²⁴ Cultural confounders, such as varying interpretations of the same set of interactions between older adults, need to be examined further.

Sexual orientation. Identifying one's self as a lesbian, gay, bisexual, or transgender (LGBT) person is an additional risk factor for elder abuse. In 1997, a report described a nursing home employee who refused to bathe a resident because he didn't want to "touch the lesbian."²⁵ Despite evolving attitudes in society toward support and acceptance of sexual orientation, fear of homophobia still prevents some LGBT older adults from seeking help when they have been abused because of their orientation—especially ones who have internalized that homophobia and feel that they are unworthy of seeking help.²⁵

In addition, health care providers and nursing home staff members might neglect the particular care needs of LGBT older adults, intentionally or unintentionally. APS staff and providers must be cognizant of underlying biases and exhibit respect when assisting LGBT clients.

Approximately 75% of caregivers of older adults are family members; 70% are female²⁶; and most are adult children, spouses, and partners of those receiving care.²⁷ Male caregivers age ≥ 40 are more likely to be the abuser, however, especially when they possess any of these risk factors: fatigue, burnout, medi-

cal illness, mental illness, lack of financial and support services, family history of abusive behavior, and substance abuse.⁴ People who commit elder abuse also tend to be significantly dependent on the person they are abusing.² In some cases, and especially when the abuser is financially needy, caregivers turn to elder abuse to obtain resources from the victim.²

From your standpoint as a practitioner, it is important to determine the root cause of elder abuse. According to one review,²⁸ family members with mental illness or a history of substance abuse, or who are stressed by the burden of caregiving, abuse older adults at a higher rate than family members who are not affected in those ways. Depression in particular is a common characteristic of abusers,² often secondary to the stress of caring for an older adult.

Abuse caused by stress can be addressed by referral to a support group and counseling for the caregiver; psychiatric conditions, such as depression, might be better treated with pharmacotherapy. Evaluate for depression and posttraumatic stress disorder (PTSD) in both the abuser and the abused,²⁹ and for other mental health issues that might compound the situation. It is possible for you to have 2 patients: the older adult and his caregiver. Regardless of the challenge, keep in mind that the older adult's safety is your priority.

Consequences for the abused

The abused adult is at risk of a number of serious physical and psychological consequences.³⁰ They tend to have a shorter lifespan, after adjusting for other variables associated with increased mortality.

The reason for shortened lifespan is multifactorial³⁰:

- Bruises, abrasions, and fractures may take longer to heal because of diminished skin and bone regeneration.
- Diseases that affect the heart, lungs, and kidneys might prevent the person from bouncing back from major stressors caused by abuse, such as blood loss, severe injury, and pain.
- Injury from abuse can exacerbate an underlying illness.



Elder abuse

Clinical Point

Be on the lookout for larger bruises, rashes that do not heal, and burns in older adults, which might be evidence that they have been abused

• Elder abuse also is associated with increased emergency department use, hospitalization (including readmission within 30 days), and nursing home placement.³¹

Elder abuse can lead to depression, shame, and guilt; increased isolation; and increased risk of alcohol abuse and substance use.³¹ A study found that victims of elder abuse are significantly more depressed than non-victims.³²

In the same study, being a victim of abuse was found to be the second-strongest predictor of depression, after the state of one's health.³² Other potential psychiatric consequences of abuse that need further study include increased risk of developing fear and anxiety disorders; learned helplessness; and PTSD.³³ According to LoFaso, "depression and anxiety can consume their days and leave them emotionally and physically frail."²⁹ Such feelings make these older adults less likely to resolve abuse or break off relations with the abuser.³²

Because mental illness can be a risk factor for, and a consequence of, elder abuse, be aware of such complications and address them appropriately. Keep in mind that older adults are more likely to visit a primary care practitioner than a psychiatrist for a routine health check-up or evaluation of initial cognition-related problems; however, they are more likely to see a psychiatrist for advanced neuropsychiatric problems such as dementia, paranoia, delusions, hallucinations, and insomnia. Adequate education on elder abuse should not be limited to a single medical specialty because it can present in several clinical settings.

Identifying abuse

Identification of elder abuse in the home poses a greater challenge to clinicians than abuse in an institutional setting because it is not directly observable. Compounding this is the lack of unified standards for identifying and dealing with elder abuse.

It is first necessary for you to determine the likelihood that abuse or neglect occurred, which can be difficult because the signs of elder abuse and manifestations of normal aging often are similar. You also must establish whether (1) the abused

person will accept intervention and (2) the abused person who refuses intervention has the capacity to make that decision. Both of these conditions will guide your approach to management.²

Obtain the history from several sources; review the records; and carefully examine patterns of injury, in particular assessing functional status and level of dependency on the caregiver. Explanations that do not match injuries signal the need for further investigation and examination.

To help differentiate elder abuse from normal physiologic aging, look at the skin for bruises, rashes that do not heal, and ulcers—all of which could be signs of abuse or neglect. Keep in mind that bruising generally is more common in older adults because of the slower turnover rate of epidermal cells; physiologic bruising tends to occur on dorsal aspects of the hands and arms.⁴ In contrast, bruising secondary to neglect or physical abuse can manifest as a subgaleal hematoma (caused by traumatic hair pulling), tracking in the peritoneum after genital trauma, Battle's sign, and raccoon eyes, among other findings.⁴

In addition, larger bruises (>5 cm in diameter) are more likely the result of elder abuse.³⁴ To complicate matters, many older persons are taking anticoagulant therapy, making bruising more likely.

In addition, be on the lookout for burns during the physical exam. Evidence suggests that at least 10% of burns caused by battery and assault occur in the context of elder abuse; most burn facilities do not have formal guidelines for screening for abuse and neglect, however.³⁵ According to one retrospective study, the most common causes of burns in older adults are hot water scalds and radiator contact, and the mortality rate of older burn patients in general is higher than among the overall population.³⁶

Falls and fractures are common among older adults, regardless of whether they are abused, because of polypharmacy, underlying medical conditions, and functional limitations. Many abusers, however, use these factors to cover up intentional injury that might have resulted in the older person falling, including overmedication (a form of physical abuse) and withholding a necessary

Types of elder abuse and corresponding findings

Type of abuse	Findings
Physical	Fractures, welts, lacerations, bite marks, burns, bruises, untreated injuries, internal injuries, repeated history of falls, repeated emergency department visits, traumatic alopecia
Sexual	Difficulty walking or sitting, pain or itching in the genital area, unexplained sexually transmitted infections, vaginal or anal bleeding, torn, stained, or bloody underclothing, bruising around genital or breast regions
Psychological and emotional	Emotional upset, agitation, depression, suicidal ideation, hypervigilance toward abuser, withdrawn, unusual behavior such as sucking, biting, rocking, crying, self-mutilation
Financial exploitation	Sudden changes in bank accounts, inability to afford medications, unexplained disappearance of possessions, unexplained asset transfers, unexplained loss of pension or Social Security checks
Neglect by caregiver	Dehydration, malnutrition, decubitus ulcers, unexplained deterioration in health, failure to thrive, lack of routine medical care or medications, urine burns, multiple hospital and emergency department admissions, repeated falls, poor hygiene, unexplained weight loss

Source: Adapted from reference 37

walking aid (a form of neglect). Maintain a high index of suspicion of elder abuse when (1) the caregiver's and the older adult's stories of an injury don't add up and (2) physical findings that might have been caused by abuse are present.

A number of psychiatric and cognitive symptoms suggest other types of elder abuse. Take note of emotional upset, agitation, and unusual behaviors³⁷—especially if you can follow the patient over time to observe marked changes in the presentation. Likewise, be aware of proposed alterations in guardianship, which should be evaluated by a forensic psychiatrist with analysis of medical history, social attachments, home environment, self-care, and finances.³⁸ Such evaluation should provide clues to the motivation behind a change of guardianship and will help to determine if elder abuse should be suspected.

Brandi et al³⁷ provided an informative table that identifies pertinent signs, symptoms, and other findings that clinicians should be aware of to support a suspicion of elder abuse (*Table*).

Documentation is of utmost importance in evaluating potential elder abuse; keep in mind that the medical record might be used in an investigation of abuse by social workers, law enforcement, and prosecutors.

Your records should be legible, clearly indicate who the main caregiver is and what his (her) responsibilities are, and specify who is present at your encounter with the patient.⁴ Document your observations of patient behavior, reactions to questions, and family dynamics and conflicts¹⁶; make note of warning signs such as fear, silence, and inability to interview the patient alone.

In addition to written documentation, take photographs of injuries, with a ruler in the image to record their size. Serial photographs are helpful; so are photographs from a variety of distances (close-up, regional, whole-body) to capture detail and place the wound in the context of a specific area of the body.⁴

Safety is paramount. Given the findings of the history and physical exam, it is necessary to determine whether it is safe for the patient to return home with the caregiver, or if alternate accommodations or resources, such as a social worker or a support group, are required. Include details of planned follow-up in your evaluation, and offer consideration of possible psychiatric disorders that can develop as a result of such abuse.

Reporting

Elder abuse is a criminal offense in all states.³⁹ A clinician who has reasonable

Clinical Point

In addition to written documentation of your findings, take photographs of injuries with a ruler placed in the image, to record the size of injury



Elder abuse

Clinical Point

In a study, 94% of physicians who noted possible abuse said they either were unable to prove it had occurred or decided not to report it

suspicion that elder abuse occurred must report it, regardless of whether the proof of abuse is concrete.⁴⁰ At a point of reasonable suspicion, immediately contact APS, law enforcement, and a social worker.

Adult Protective Services, modeled after Child Protective Services, is typically administered by local and state health departments.⁴¹

After a report is filed with APS, an assigned social worker makes an in-person home visit to investigate the allegation and determine whether elder abuse is substantiated, partially substantiated, or unsubstantiated.¹⁶ In most states, elder abuse reporting is *not* anonymous because follow-up may be needed to provide additional evidence, especially if the report was made by a health care provider.¹⁶

No federal standard exists for states to follow when defining and addressing elder abuse, which can complicate identification and reporting of abuse. Laws governing elder abuse do not allow states to determine the fate of the older adult, who can decide for himself (herself) whether to use or waive protective services.⁴² Older adults might choose not to report abuse because of shame, intimidation, or fear,⁴³ or to protect a caregiver, who often is a family member.

Elder abuse reports can come from a variety of sources; convincing evidence is, as noted, unnecessary to report it. Health care providers are mandated reporters, but it is believed that the number of clinicians who report elder abuse based on suspicion is far below what it should be. One study found that 94% of physicians said that they either were unable to prove that the abuse had occurred or decided not to report it.¹¹ Another study found that only 1.4% of elder abuse cases reported to APS come from physicians.⁴⁴

There are several possible reasons for underreporting elder abuse, including (1) the difficulty of distinguishing elder abuse and neglect from sequelae of normal aging and (2) the fact that cognitive and functional impairment of the abused person makes it difficult, even impossible, to establish the narrative of how the abuse happened. Nursing homes in particular provide

a high level of oversight because residents have an average of ≥ 3 functional deficits.⁴

Other reasons for underreporting—some of which are difficult to understand, and excuse, in a clinician—are:

- subtlety of signs
- victim denial
- ignorance of reporting procedures
- inadequate training
- lack of information about resources
- concern about losing physician–patient rapport
- concern about involvement in the legal system
- time limitations
- doubt about the effectiveness of APS.¹⁶

Assessing capacity

The older adult's wishes must be respected unless a health care provider or the legal system determines that he lacks functional capacity to make decisions.¹⁶

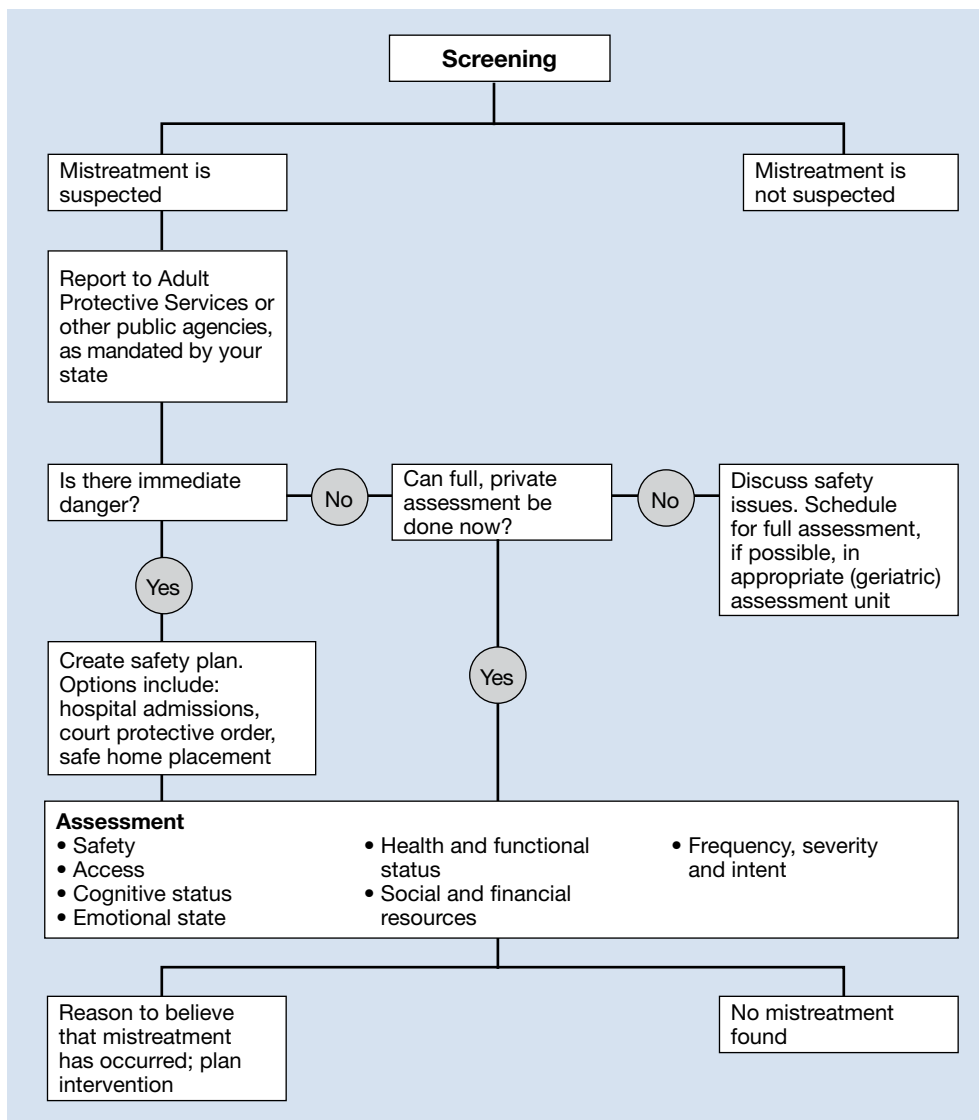
How is capacity evaluated? A capacity evaluation has 3 components:

- **Comprehension** is a person's factual understanding of the situation, including consequences and alternatives
- **Free choice** is a person's voluntary decision to accept or reject a proposed treatment, free of coercion (in this setting, free choice is the older adult's decision whether to report the abuse)
- **Reliability** is a person's ability to provide a consistent choice over time.⁴⁵

Most capacity evaluations are conducted by clinical interview. No single, brief test is used universally, and there is the possibility of inter-rater variability.⁴⁵ Examples of tests used to assess capacity are the Folstein Mini-Mental Status Examination and the MacArthur Competence Assessment Tool–Treatment⁴⁵; the latter is a structured interview that incorporates information specific to the individual patient's decision-making situation.⁴⁶ Regardless of the approach, the psychiatrist-evaluator ensures that the older adult has been given the appropriate information to provide informed consent about the situation.⁴⁷

If the evaluator determines that a person lacks capacity to make decisions, efforts

American Medical Association's guidelines for diagnosing and treating elder abuse and neglect



Clinical Point

Choose carefully if you are involved in identifying a decision-maker to speak on behalf of an older adult: Abusers are often a family member

should be made to determine if the cause of that impairment is reversible.⁴⁷ Older adults who have dementia or other underlying psychiatric condition that impairs cognition might benefit from more education on their situation; ones who appear fearful of consequences should be introduced to a trusted advisor to assist in making competent judgments.⁴⁷

If the older adult is found to lack capacity, a substitute decision-maker must be sought.⁴⁷ Many states have statutes specifying the order in which family members are contacted.⁴⁸ The need to appoint an advisor can

become knotty because the suspected abuser often is a family member; clinicians and others involved in identifying a decision-maker to speak on behalf of an older adult should choose carefully.

Prevention and screening

Key to reducing the prevalence of elder abuse in the community is formulating strategies for prevention and screening. The American Medical Association recommends that clinicians “incorporate routine questions related to elder abuse and neglect



Elder abuse

Clinical Point

The AMA recommends that you incorporate routine questions related to elder abuse and neglect into daily practice

into daily practice.⁴⁹ Older adults might not admit to abuse or neglect unless they are asked; speak to patients at eye level, keep questions simple, direct, and nonjudgmental, and assure them (1) that discussions are confidential and (2) that their safety is your primary goal.^{50,51}

Comprehensive approaches to questioning patients are available and often recommended for screening for elder abuse.⁴ However, screening in the office setting often involves short, directly administered questionnaires.⁴⁹ For example, the Health and Safety Screen developed at the University of Maine comprises 6 questions⁵²:

- Has anyone close to you called you names or insulted you recently?
- Are you afraid of anyone in your life?
- Are you able to use the telephone anytime you want to?
- Has anyone forced you to do things you didn't want to do?
- Has anyone taken things or money that belong to you without your OK?
- Has anyone close to you tried to hurt you or harm you recently?

Because of time constraints and lack of a universal standard, there is debate whether regular elder abuse screening is time-effective. It often is recommended, therefore, that clinicians in primary care (1) refer older adults with risk factors for abuse to geriatric medical teams trained in these measures and (2) perform periodic follow-up on such patients⁴ (Figure, page 35).

Because of limitations to regular screenings, the best method of prevention might be to raise awareness of elder abuse among clinicians and in the community. For example:

- **New York City Elder Abuse Center** encourages collaboration among health, mental health, and community justice organizations.²⁸ The program involves a number of resources for addressing elder abuse, such as promoting staff awareness of risk factors for, and signs of, abuse, and screening for mental health problems in the abused.

- **The Elder Justice Act**, enacted in 2010 to combat elder abuse, provides federal funds and resources to prevent, detect, treat, and intervene to stop abuse and, when appropriate, to prosecute abusers.⁵³

See this article at CurrentPsychiatry.com for a **Table** that provides a 7-point summary reference guide for understanding and preventing elder abuse in your practice.

References

1. The Elder Abuse Prevention, Identification, and Treatment Act of 1985, HR 1674, 99th Cong (1985).
2. Lachs MS, Pillemer K. Elder abuse. *Lancet*. 2004;364(9441):1263-1272.
3. Johannesen M, LoGiudice D. Elder abuse: a systematic review of risk factors in community-dwelling elders. *Age Ageing*. 2013;42(3):292-298.
4. Gibbs LM, Mosqueda L, eds. Medical implications of elder abuse and neglect. *Clin Geriatr Med*. 2014;30(4):xv-xvi. doi: 10.1016/j.cger.2014.08.015.
5. Werner CA. The Older Population: 2010. U.S. Census Bureau. http://webcache.googleusercontent.com/search?q=cache:hCCb_pcnO6QJ:https://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf+&cd=1&hl=en&ct=clnk&gl=uss. Issued November 2011. Accessed October 10, 2015.
6. Himes CL. Elderly Americans. *Population Bulletin*. 2002; 56(4):1-41.
7. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing*. 2008;37(2):151-60.
8. Teaster PB. A response to the abuse of vulnerable adults: the 2000 Survey of State Adult Protective Services. The National Center on Elder Abuse. <http://www.ncea.aoa.gov/Resources/Publication/docs/apsreport030703.pdf>. 2003. Accessed October 22, 2015.
9. Mouton CP, Rodabough RJ, Rovi SL, et al. Prevalence and 3-year incidence of abuse among postmenopausal women. *Am J Public Health*. 2004;94(4):605-612.
10. Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the National Elder Mistreatment Study. *Am J Public Health*. 2010;100(2):292-297.
11. Kennedy RD. Elder abuse and neglect: the experience, knowledge, and attitudes of primary care physicians. *Fam Med*. 2005;37(7):481-485.
12. Statistic Brain Research Institute. Elderly abuse statistics. <http://www.statisticbrain.com/elderly-abuse-statistics>. Accessed June 22, 2015.
13. Lachs MS, Bachman R, Williams CS, et al. Resident-to-resident elder mistreatment and police contact in nursing homes: findings from a population-based cohort. *J Am Geriatr Soc*. 2007;55(6):840-845.
14. Lachs M, Bachman R, Williams C, et al. Older adults as crime victims, perpetrators, witnesses, and complainants: a population-based study of police interactions. *J Elder Abuse Negl*. 2005;16(4):25-40.
15. Acierno R, Hernandez-Tejada M, Muzzy W, et al. National Elder Mistreatment Study. Washington, DC: National Institute of Justice; 2009.
16. Dong XQ. Elder abuse: systematic review and implications for practice. *J Am Geriatr Soc*. 2015;63(6):1214-1238.
17. Freedman M. The growing epidemic of financial elder abuse. *The Tax Advisor*. http://www.cpa2biz.com/Content/media/PRODUCER_CONTENT/Newsletters/Articles_2007/Tax/Financial_Elder_Abuse.jsp. Published November 2007. Accessed June 24, 2015.
18. Consumer Financial Protection Bureau. Protection for older Americans. <http://www.consumerfinance.gov/older-americans>. Accessed June 22, 2015.
19. Castle NG. Nursing home deficiency citations for abuse. *J Appl Gerontol*. 2011;30(6):719-743.
20. Elder Abuse Prevention Unit. Social abuse. <http://www.eapu.com.au/elder-abuse/social-abuse>. Published 2014. Accessed June 24, 2015.
21. Former nursing home employees allegedly photographed naked resident. *United Press International*. http://www.upi.com/Top_News/US/2013/07/03/Former-nursing-home-employees-allegedly-photographed-naked-residents/65801372893020. Published July 3, 2013. Accessed June 24, 2015.
22. Miller N. Two charged with elder assault at an assisted living facility. *MetroWest Daily News*. <http://>

See this article at

CurrentPsychiatry.com

for a table that provides a 7-point guide for clinicians for understanding and preventing elder abuse



Elder abuse

Clinical Point

Screening in the office setting for abuse in an older adult often involves one of several short, directly administered questionnaires

Related Resources

- Frazão SL, Correia AM, Norton P, et al. Physical abuse against elderly persons in institutional settings. *J Forensic Leg Med.* 2015;36:54-60.
- Sorrentino R. Performing capacity evaluations: what's expected from your consult. *Current Psychiatry.* 2014;13(1):41-44.

- www.metrowestdailynews.com/article/20140506/NEWS/140507587. Updated May 7, 2014. Accessed June 24, 2015.
23. Jorgensen J. New charges filed in nursing home case. WHAS11. <http://www.whas11.com/story/news/local/2015/06/24/new-charges-filed-in-nursing-home-case/29243183/>. Published June 24, 2015. Accessed June 27, 2015.
 24. Hernandez-Tejada MA, Amstadter A, Muzzy W, et al. The National Elder Mistreatment Study: race and ethnicity findings. *J Elder Abuse Negl.* 2013;25(4):281-293.
 25. Cooks-Daniels L. Lesbian, gay male, bisexual and transgendered elders: elder abuse and neglect issues. *J Elder Abuse Negl.* 1998;9(2):35-49.
 26. Zarit SH, Reever KE, Bach-Peterson J. Relatives of the impaired elderly: correlates of feelings of burden. *Gerontologist.* 1980;20(6):649-655.
 27. Tataru T, Blumerman Kuzmeskus L, Duckhorn E, et al. The National Center on Elder Abuse Incidence Study: final report. http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf. Published September 1998. Accessed October 19, 2015.
 28. Rosen AL. Where mental health and elder abuse intersect. *Generations.* 2014;38(3):75-79.
 29. LoFaso V. The role of the primary physician in assessing and treating the mental health concerns of elder abuse victims. NYC Elder Abuse Center eNewsletter. nyceac.com/wp-content/uploads/2013/03/Exploring-the-Intersection-of-Elder-Abuse-and-Mental-Health_eNewsletter.pdf. Published March 12, 2013. Accessed August 20, 2015.
 30. Lachs MS, Williams CS, O'Brien S, et al. The mortality of elder mistreatment. *JAMA.* 1998;280(5):428-432.
 31. Dyer CB, Pavlik VN, Murphy KP, et al. The high prevalence of depression and dementia in elder abuse or neglect. *J Am Geriatr Soc.* 2000;48(2):205-208.
 32. Pillemer K, Prescott D. Psychological effects of elder abuse: a research note. *J Elder Abuse Negl.* 1988;1(1):65-73.
 33. Elder abuse: consequences. Centers for Disease Control and Prevention. <http://www.cdc.gov/violenceprevention/elderabuse/consequences.html>. Updated June 22, 2015. Accessed August 20, 2015.
 34. Wiglesworth A, Austin R, Corona M, et al. Bruising as a marker of physical elder abuse. *J Am Geriatr Soc.* 2009;57(7):1191-1196.
 35. Peck MD. Epidemiology of burns throughout the World. Part II: intentional burns in adults. *Burns.* 2012;38(5):630-637.
 36. 2014 National Burn Repository; report of data between 2004-2013. American Burn Association. <http://www.ameriburn.org/2014NBRAnnualReport.pdf>. Published 2014. Accessed June 26, 2015.
 37. Brandi B, Dyer CB, Heisler CJ, et al. Systemic responses to elder abuse. In: Brandi B, Dyer CB, Heisler CJ, eds. *Elder abuse detection and intervention: a collaborative approach*. New York, NY: Spring Publishing Company; 2007:79-100.
 38. Welner M. Guardianship. The Forensic Panel. http://www.forensicpanel.com/expert_services/psychiatry/civil_law/guardianship.html. Accessed August 20, 2015.
 39. Watson E. Elder abuse: definition, types and statistics, and elder abuse (mistreatment and neglect) laws. *Journal of Legal Nurse Consulting.* 2013;24(2):40-42.
 40. National Center on Elder Abuse Administration on Aging. Reporting abuse. http://www.ncea.aoa.gov/Stop_Abuse/Get_Help/Report/index.aspx. Accessed August 18, 2015.
 41. Mukherjee D. Organizational structures of elder abuse reporting systems. *Administration in Social Work.* 2011; 35(5):517-531.
 42. Costin LB, Karger HJ, Stoesz H. *The politics of child abuse in America*. New York, NY: Oxford University Press; 1996.
 43. Thomson MJ, Lietzau LK, Doty MM, et al. An analysis of elder abuse rates in Milwaukee County. *WMJ.* 2011; 110(6):271-276.
 44. Teaster PB, Dugar TA, Mendiondo MS, et al; The National Committee for the Prevention of Elder Abuse; The National Adult Protective Services Association. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years and Older*. http://www.ncea.aoa.gov/Resources/Publication/docs/APS_2004NCEASurvey.pdf. Published March 2007. Accessed October 19, 2015.
 45. Sorrentino R. Performing capacity evaluations: what's expected from your consult. *Current Psychiatry.* 2014; 13(1):41-44.
 46. Grisso T, Appelbaum PS. *MacArthur competence assessment tool for treatment (MacCAT-T)*. Sarasota, FL: Professional Resources Press; 1998.
 47. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med.* 2007;35(18):1834-1840.
 48. Wynn S. Decision by surrogates: An overview of surrogate consent laws in the United States. *Bifocal: A Journal of the ABA Commission on Bar and Aging.* 2014;36(1). http://www.americanbar.org/publications/bifocal/vol_36/issue_1_october2014/default_surrogate_consent_statutes.html. Accessed October 22, 2015.
 49. American Medical Association. *Diagnostic and treatment guidelines on elder abuse and neglect*. Chicago, IL: American Medical Association; 1992.
 50. Harrell R, Toronjo C, McLaughlin J, et al. How geriatricians identify elder abuse and neglect. *Am J Med Sci.* 2002;323(1):34-38.
 51. Ahmad M, Lachs MS. Elder abuse and neglect: what physicians can and should do. *Cleve Clin J Med.* 2002; 69(10):801-808.
 52. Elder abuse screening protocol for physicians: lessons learned from the Maine Partners for Elder Protection Pilot Project. University of Maine Center on Aging. http://umcoa.siteturbine.com/uploaded_files/mainecenteronaging.umaine.edu/files/elderabusescreeningmanual.pdf. Published May 2, 2007. Accessed August 20, 2015.
 53. What is the Elder Justice Act? USC Davis School of Gerontology. <http://gerontology.usc.edu/resources/articles/what-is-the-elder-justice-act/>. Published 2015. Accessed October 20, 2015.

Bottom Line

Identification of elder abuse can be difficult because signs and symptoms of abuse closely resemble physiologic aging. Older adults with identifiable risk factors should be screened for abuse; time constraints make universal screening impossible at this time. In the future, multidisciplinary approaches likely will make elder abuse more easily identifiable through the combined work of health care providers, law enforcement agencies, banks, and other institutions—with the ultimate goal of protecting older adults in the community from abuse.

7-Point reference guide for understanding and preventing elder abuse

1. Necessary components

- Abuser
- Older victim
- Relationship of trust

2. Five primary types

- Neglect
- Physical
- Financial
- Psychological and emotional
- Sexual

3. Risk factors

- Burnout
- Cognitive impairment or mental health problems (especially dementia and depression)
- Family history of abusive behavior
- Family disharmony
- Fatigue
- Functional deficiency
- Gay or lesbian older adults
- Low income
- Low social support
- Substance abuse

4. Suspicious findings on physical exam

- Abnormal pattern of bruising
- Burns
- Dehydration
- Difficulty walking or sitting
- Falls
- Fractures
- Head injury
- Hyperthermia and hypothermia
- Infection
- Malnutrition
- Non-healing rash
- Rhabdomyolysis
- Strangulation
- Ulcers

5. Role of the health care provider

- Obtain the history from several sources
- Assess patterns of injury (ie, differentiate injury from physiologic aging)
- Document possible abuse (include photos and observations of patient behavior when possible)
- Assess functional status and level of dependency on caregiver
- Determine if the abused patient will accept intervention; the patient's wishes must be respected unless he (she) is deemed functionally unable to make decisions

6. Reporting

When abuse is suspected, immediately contact adult protective services, law enforcement, and a social worker^a

7. Prevention

Refer patients who have risk factors to a geriatrician for screening of elder abuse. Raise awareness among colleagues and in the community

^aClinicians are mandated reporters