Elder Abuse

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Case Vignette

An 88-year-old female is transferred late in the day with a report of falling the previous night and striking her eye on the bedside table. She was initially evaluated at an outside emergency room and then was seen by the local ophthalmologist with a diagnosis of an open globe injury. She was subsequently referred to the university hospital for further evaluation and treatment. She is agitated, abusive, and quite unhappy at having multiple exams by both the resident on service and the faculty. She threatens to leave without allowing further evaluation or surgical correction. The emergency room nurse checks the patient's blood pressure, which is elevated and has been climbing throughout her visit. The clinician sits and speaks quietly with the patient and family, eventually gaining her trust and cooperation.

The patient is confused regarding the cause of her fall. She habitually prefers an edge-of-bed sleeping position and states she may have rolled out of bed. Her family reports some generalized increase in confusion within the last few months, as well as an increasing problem with urinary frequency, both of which may have contributed to the fall as she has been getting up at night more to urinate. They report a past medical history of treated hypertension, and her review of recent symptoms shows a series of recent falls. These falls do not appear to be due to poor prior vision. She has already undergone

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bilateral cataract surgery and functions well visually but preoperatively had been highly myopic. Her exam confirms scleral rupture with uveal prolapse as well as multiple fading bruises on the extremities and trunk.

The clinician discusses the injury and the multiple ecchymoses with the patient again while she is alone. They ask her several times by varying approaches if she feels safe in her home and if she feels she is physically threatened or afraid. She states she feels unsafe in her home but that it is "all her fault" and that her children help her with her personal needs "whenever she asks for help." She denied that she has received any direct physical threats and has had no items taken from her against her wishes. Her children are all well employed, lead busy lives, and are financially stable without asking her for funds. The patient undergoes orbit and head CT in the emergency department and subsequent repair of an extensive scleral rupture with repositioning of prolapsed uvea, but she remains no light perception vision.

The postoperative course becomes complicated the next morning. The patient develops poorly controlled hypertension and worsening generalized confusion, prompting a consult to internal medicine. Their service modifies her medications and recommends physical therapy and occupational therapy in preparation for eventual discharge. Additionally, although they consider her mentally competent, they feel she is physically unable to independently return to her home. Physical therapy finds that she is only able to walk halfway across the room without assistance. You discuss this with her daughter; a family meeting is scheduled to discuss employing an "in-home" elder care worker. A home review for falling hazards is also arranged through the patient's family physician, including installment of bed rails and evaluation for trip hazards. Physical and occupational therapies begin a program of rehabilitation with the goal of reconditioning her to allow independent living.

The clinician and patient discuss hospital protocol, which requires a living will and medical power of attorney to be filed in the medical record for all admissions. The patient expresses a strong preference to retain a full code status. The clinician prepares her for transfer to a skilled care facility to work on strength training and during a review of her electronic record reviews the final radiology report from her admission orbital CT. The radiologist suspects normal pressure hydrocephalus (NPH) based on the brain imaging associated with the orbital films. The clinician performs a review of the clinical signs and symptoms of NPH and then speaks with the children at the family meeting. Each child maintains loose contact with the mother, and they reveal that she has been partially bedridden for several months with depression over the recent loss of her spouse. The patient states that her falling episodes preceded his death and after some questioning reveals that the falls and her urinary symptoms have been increasing. She is reluctant to discuss her physical condition and insists that she is fine, but the children together are able to determine that she is now falling several times weekly. She still maintains that she is able to

return home unassisted. The clinician consults the neurology service, which confirms a likely diagnosis of NPH, recommending physical and occupational therapy to maximize the patient's physical condition. They reserve making a final diagnosis of NPH without demonstrated improvement in independent functional status after a high-volume lumbar tap. This assessment would not be currently interpretable given the patient's debilitated physical state. Both neurology and physical therapy recommend skilled care nursing for physical rehabilitation prior to an attempted high-volume lumbar tap. This is arranged through a Social Work Consult. The patient continues to be followed by ophthalmology and her primary service, and her vision remains no light perception. The oculoplastic service is therefore consulted for anticipated enucleation within 2 weeks from her injury. She undergoes an uneventful enucleation, is placed in safety lenses, and is discharged to skilled care on postoperative day one.

Patient Care

This scenario gives an excellent demonstration of the patient care competency. The clinician communicates well throughout the case, first seen in the emergency department, where they calm the patient and gain her trust and that of the family. The clinician helps the patient to maintain her dignity, taking the medical history directly from her despite her confusion; the family was included in the discussion to ensure the accuracy of the history.

The patient care competency covers maintenance of health and prevention of further medical problems. In this case, the most important immediate health maintenance issue is the possibility of elder abuse. There are 700,000–1.2 million cases of elder abuse annually in the United States [1, 2]. Ten percent of elderly adults are felt to be abused annually in the United States with a medical cost of $5.3 billion. However, it is estimated that currently only 1 in 24 cases is reported. Many of these patients report to emergency departments for trauma and are released without the abuse being identified. Recognizing injury patterns in elder abuse, similar to recognizing patterns in child abuse, would be useful for emergency personnel and consultants. Rosen et al. reviewed all emergency department records on patients with confirmed diagnoses of elder abuse from 1981 to1994 and ranked the probability of the visit causes having been from abuse. Thirty-one visits of 26 patients caused by abuse were compared to 108 visits of 57 patients with indeterminate probability of abuse and with accidental trauma. They found that upper extremity, lower extremity, and head or neck injury were the presenting complaint in 45%, 32%, and 42% of visits felt to be from abuse, with bruising noted in 39%. Although bruising was in multiple regions in 69% when present, the most common location of bruising was the eye/orbit and of injury was the upper extremity. Bruising of the ulnar or lateral right arm and fractures of the midface and left zygoma (right-handed abuser) were more common in abuse and less commonly found in accidental trauma. In the indeterminate group, injuries 1 day or older and those to the maxillofacial region or upper extremity were felt to be more suspicious for nonaccidental trauma [3]. Other

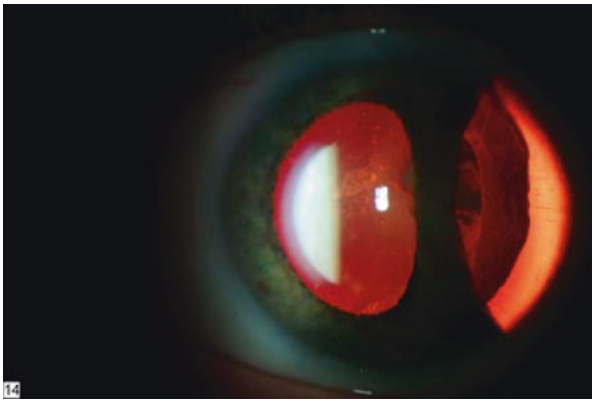

Fig. 1 Any evidence of significant ocular trauma in an older patient should raise the possibility of elder abuse. This patient received blunt trauma resulting in a traumatic cataract and iridodialysis. (Reprinted with permission from the Department of Ophthalmology, the University of Iowa Carver College of Medicine)

ophthalmic findings of adult abuse include lens dislocation, cataract, orbital fracture, and retinal detachment (Fig. 1) [4].

Internationally 2–10% of patients over the age of 65 report a history of maltreatment [5], and some extreme cases include labeling elderly women as "witches," seizing of their property, and abandonment [5, 6]. The US Adult Protective Services report a 19.7% increase in reports of elder abuse from 2000 to 2004, with a similar rise in substantiated reports during that time of 15.6% [7]. Unfortunately, less than 10% of estimated cases of older adult mistreatment are ever reported [1, 2, 8, 9].

Although elder mistreatment includes physical abuse, it also includes neglect, exploitation, and abandonment and may be manifested through unwanted sexual contact, psychological abuse through humiliation or intimidation, and financial exploitation [1, 2, 5, 6, 8, 10, 11]. Interestingly, neglect can also include "self-neglect" (when the patient is unwilling or unable to care for themselves), but this may coexist with caregiver neglect where the caregiver fails to intervene in the self-neglect [1, 7, 9, 11]. Although some abused elder patients complain of mistreatment, some patients may simply exhibit unexplained signs of physical trauma, poor hygiene, malnutrition, or dehydration [1, 8, 10]. In other patients, they may simply appear to be withdrawn or may manifest symptoms of nonspecific anxiety or depression. The possible warning signs may be as simple as broken spectacles without explanation, noncompliance with prior treatment instructions, or unexplained missed appointments and thus do not have to include direct evidence of ocular or periocular trauma. Cases of suspected abuse should be reported to the authorities, and reporting is mandatory in 42 states [10, 12]. The clinician in this case recognizes the risk of abuse in this elderly patient and pursued it appropriately. The diagnosis is suggested not only by the severe ocular trauma in this case but also by multiple ecchymoses evidencing past trauma of different times.

A highly sensitive but nonspecific test for elder abuse is the Elder Assessment Instrument (EAI). This 41-point Likert scale reviews signs, symptoms, and complaints consistent with elder mistreatment and requires approximately 12–15 min to complete. The EAI includes a general assessment of clothing, hygiene, nutrition, skin, and any evidence of trauma or sexual abuse. It includes self-reported

comments of neglect, abuse, abandonment, or exploitation, evidence of depression, and any physical signs of neglect including decubiti, contractures, diarrhea, urine burns, impaction, and evidence of poorly monitored medication (over or under-medication) or healthcare regimens. Additional evidence of either misuse of finances or caregiver demands for financial reimbursement and abandonment by the caretaker for periods inappropriate to the patient's needs conclude the EAI. Although there is no specific scoring protocol for the EAI, any evidence of abuse, neglect, exploitation, or abandonment should be reported to the proper authorities for further investigation [1]. Currently health professionals underreport suspected mistreatment, in part from missed diagnoses and in part due to conflicts over reporting the information counter to the wishes of their competent older patient. These patients may have guilt about or fear of retribution, institutionalization, or embarrassment by the exposure of their situation and may refuse assistance [1, 2, 5, 9, 11].

Five Common Manifestations of Adult Maltreatment (Adapted from Lachs et al. [5])

- Physical abuse: intentionally causing physical pain or injury
- Psychological abuse: intentionally causing emotional pain or injury
- Sexual assault.
- Material exploitation: misappropriation of money or property
- Neglect: failure of caregiver to meet the needs of dependent elderly

Among the types of elder abuse, self-neglect is the most common; both suspected and confirmed self-neglect have been found to increase the frequency of hospital admission. Dong et al. in the Chicago Health and Aging Project (CHAP) studied 1165 of 6864 total participants, identified by social services for suspected self-neglect as an independent variable, evaluated after eliminating confounding variables of older age, lower socioeconomic status, number of comorbid conditions, cognitive function, and overall health. This group was found to have higher rates of annual hospitalization (RR, 1.47, 95% CI, 1.39–1.55). Greater severities of self-neglect were found to have serially higher rates of annual hospitalization (mild self-neglect (PE, 0.24; SE, 0.05; RR, 1.28, 95 CI%, 1.16–1.41, $p < 0.001$), moderate self-neglect (PE, 0.45; SE, 0.03; RR, 1.57, 95% CI, 1.48–1.67, $p < 0.001$), and severe self-neglect (PE, 0.54; SE, 0.11; RR, 1.72, 95% CI, 1.39–2.12, $p < 0.001$)). Similar results were found in cases with confirmed self-neglect [13].

Abuse increases mortality in elderly patients [5], and the psychosocial health of the patient may influence the effect of abuse on the mortality rate. Our patient was known by her family to be more socially withdrawn and depressed after the death of her spouse. Though there was family living near the patient, their busy lives led to infrequent visits. Dong et al. studied the association of elder abuse, psychosocial health, and mortality through the Chicago Health and Aging Project (CHAP). The psychosocial categories considered were depression, social support (children, relatives, and friends seen at least monthly), and social engagement (social activities

outside the house). Dong further differentiated between reported and confirmed elder abuse in these patients 65 and older. When evaluating depressive symptoms, the presence of reported abuse increased the mortality rate in the most depressed (HR 1.54, 95% CI 1.04–2.28) and middle tertile of depression (HR 1.76, 95% CI 1.05–2.96), though there was no increased risk to those in the lowest tertile of depression. Reported elder abuse increased mortality in the lowest tertile of social networking (HR 1.74, 95% CI 1.18–2.56), as well as in patients with the lowest tertile in social engagement (HR 1.89, 95% CI 1.29–2.77). Confirmed abuse increased mortality among the most depressed tertile (HR 2.60, 95% CI 1.58–4.28) and middle tertile (HR 2.18, 95% CI 1.19–3.99), the lowest tertile (HR 2.42, 95% CI 1.52–3.85) and middle tertile (HR 2.65, 95% CI 1.52–4.60) of social networking, and the lowest tertile (HR 2.32, 95% CI 1.47–3.68) and middle tertile (HR 2.59, 95% CI 1.41–4.77) of social engagement. This indicates that both reported and confirmed abuses are associated with an increased mortality in lower levels of both social networking and engagement and in higher levels of depression, emphasizing the importance of psychosocial health in this population [14]. This underlines the importance of immediate (family network) and local (social engagement) systems of care competency.

In our case, the clinician contributes to preventative health by addressing the patient's future risk of falling. They notified the primary physician, who arranges for home bed rail installation and fall hazard assessment. The ophthalmologist also recognizes the increased risk of ocular injury in the remaining eyes of monocular patients and prescribes the patient full-time safety glasses at discharge from the hospital. The children living closer to our patient committed to more frequent and scheduled visits in an effort to help their mother regain her independent living. They are further planning for home elder care after her discharge from rehabilitation.

Finally, the patient care competency covers not only clinician competence in medical and surgical procedures but also recognition of the need for external consultation for problems outside of an individual clinician's training. In this scenario, the clinician competently cared for her ocular injury and surgically managed her globe rupture. They interacted with outside healthcare providers for issues outside of ophthalmology, including those in emergency medicine, radiology, internal medicine, neurology, occupational therapy, physical therapy, social work, and oculoplastics. The primary ophthalmologist continued to coordinate care for the patient and to counsel the patient and the family regarding her ongoing options for treatment.

Medical Knowledge

The practitioner used their general medical knowledge to analyze the multiple presenting symptoms, diagnosing and treating the patient's ocular, hypertensive, and neurological problems. Those areas of medical care outside of the practitioner's area of practice were appropriately triaged, a coordination of care which demonstrates overlap between the medical knowledge competency and that of patient-centered care. The clinician entertained but discounted the likelihood of elder abuse as a unifying diagnosis in this case. The presentation of an elderly, confused female with severe ocular trauma and multiple ecchymoses of varying ages matches the

common profile of the abused older patient. Such abuse is usually performed in the patient's home; 90% of the time abuse is performed by the children or spouse. The victim is often physically and socially isolated, dependent, demented, elderly (especially over the age of 80), and female. Unlike the caregivers in this case, the perpetrators of elder abuse are often financially dependent on their victim. Caregivers may be under personal stress and may be ignorant about and frustrated by the demands of caring for an elder relative. The abuser manifests their desperation by intentionally inflicting pain, injury, or anguish on their elderly charge. The risk of abuse rises when there is other violence within the household, and the acts may be exacerbated by caregiver substance abuse or mental health disorders [1, 5, 8–11]. The risk is greater for the elderly living alone as there is less opportunity for contact and conflict. Abuse also occurs in institutionalized settings. Financial abuse, however, is more frequent for elders living alone. Sadly, the 3-year relative mortality in older patients with a history of abuse is 3 times that of age-matched controls [5].

Our patient was engaging in self-neglect by not reporting or seeking assistance for her falls, deconditioning, depression, and other progressing medical conditions. Self-neglect is the most common form of elder abuse and is linked to elevated morbidity and mortality, with greater neglect being associated with greater mortality. Self-neglect is associated with higher risk of nursing home placement, use of social behavioral services, and hospitalization. The Chicago Health and Aging Project (CHAP) found one in nine elderly experiences self-neglect. Using the CHAP, Dong and Simon reported an increased risk of 30-day readmission in patients with reported self-neglect (RR, 2.50, 95% CI, 2.02–3.10); increased severity of self-neglect was associated with increased 30-day readmission, increasing from mild self-neglect (PE, 1.09; SE, 0.19; RR, 3.00, 95%, 2.07–4.34, $p < 0.001$) to moderate self-neglect (PE, 0.84; SE, 0.13; RR, 2.33, 95% CI, 1.81–2.98, $p < 0.001$) to severe self-neglect (PE, 1.24; SE, 0.40; RR, 3.45, 95% CI, 1.57–7.58, $p = 0.002$) [15].

Eight Red Flags for Elder Abuse (Adapted from Purdy [12])

- Repeated visits for medical care (ER or office)
- Conflicting, non-credible history from caretaker or patient
- Unexplained delay in seeking treatment
- Unexplained, inconsistent, vague, or poorly explained injuries
- History of being "accident-prone"
- Patient ambivalence, anger, or fear toward caregiver
- Poor compliance with scheduled follow-up or care regimen
- Physical evidence of abuse

Interpersonal and Communication Skills

The sections within the interpersonal skills and communication competency also overlap with those of patient-centered care. In this case, the clinician updates the patient and their family as various medical and ophthalmologic issues develop. This

includes the care of the initial open globe injury, the subsequent poorly controlled hypertension, the diagnosis of NPH, the eventual need for enucleation, and the need for skilled care nursing for physical rehabilitation. Communication skills are needed for the discussion of the patient's mental competence and for the discussion leading to documentation of code status, a living will, and medical power of attorney.

It is important in this case to communicate with both the patient alone and also in conjunction with her family. The initial history is confirmed by the family, given the patient's confusion at presentation, but repeated with the family absent when investigating the possibility of elder abuse. The potential abuse history should be taken in a nonconfrontational, nonjudgmental fashion, as abused older patients often suffer a sense of guilt and shame regarding the abuse. Patients may deny the occurrence of maltreatment and may decline intervention on their behalf.

Nine Questions to Ask a Suspected Victim of Adult Mistreatment [2]

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any document that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?

Professionalism

The professionalism competency interweaves ethics and medicine and involves putting patient and societal needs above those of the doctor. This competency relies on the competencies of communication and patient care, without which it is difficult to recognize the patient's needs or to coordinate appropriate care. In this example, it would have been far easier for the treating ophthalmologist to address only the open globe and to discharge the patient to the care of the family and the primary physician. This would have not have addressed the possibility of elder abuse and would not have uncovered the diagnosis of NPH nor optimized her care with skilled nursing placement and rehabilitation.

Other professionalism issues arise in this case. It is in society's financial interest to address the spectrum of her acute and subacute diagnoses. Part of the professionalism domain includes placing the patient's and society's interests ahead of the physician's interests. The clinician also respects the patient's wishes for aggressive treatment despite pressure from the family. Although the patient is older and has times of confusion, she is competent to make her own decisions. She is within her

rights to prefer a full neurologic evaluation to maintain and hopefully to improve her quality of life and her activities of daily living.

Finally, by becoming involved in the extensive evaluation of this patient, the ophthalmologists themselves learned more about NPH and fall prevention in the older patient, and both educated the ophthalmology resident and the other medical teams about eye trauma. This scenario demonstrates professional, patient-centered, preventative care by addressing all of the patient's medical needs and by addressing ongoing professional development and education in both the clinician and the consulting services.

Practice-Based Learning and Improvement

There is also overlap between the practice-based learning and improvement and the professionalism competencies. The professional physician applies new knowledge gathered from each patient encounter to learn and to improve their own patient care. The physician in this scenario applies skills learned from past trauma cases and recognizes the dangers of falls in the elderly for fractures and mortality. The practice-based learning competency covers the use of information technology in managing patient care. The clinician in this case uses computer information technology to access the electronic medical record, reviewing the final CT report, as well as to access online information about NPH. Their literature search led both to specific questioning of the family and patient and to consultation of neurology.

This case was ultimately presented to departmental morning rounds as a Clinical-Pathological Conference (CPC). The CPC covered both the pathological findings and a discussion of patient-centered care, systems-based practice, and medical knowledge competencies. This case therefore provided the entire ophthalmology department an opportunity to learn, exemplifying the definition of the practice-based learning and improvement competency.

Systems-Based Practice

The system of care is particularly important in cases of suspected elder abuse. Every individual who comes in contact with older patients should be aware of the prevalence of elder mistreatment and recognize the possibility of self-neglect as abuse. A clinician suspecting neglect or abuse should access their state's reporting network. Every state has laws governing elder mistreatment, and in most states, the reporting of elder abuse is mandatory [1, 2, 10].

Elder abuse is both a social and a medical condition, as are child abuse and domestic violence. The findings of elder abuse are not specific, and there is not a specific definition of nor a specific test for the condition [5]. The abuse itself is rarely witnessed, and the victim often tries to hide the condition out of shame and to refuse intervention on their behalf [5, 9, 11]. Complicating the issue further are cultural variations on both the perception of what constitutes abuse and the

willingness to portray the family in a negative light [5, 6]. It is important as a clinician to recognize the possibility of abuse and to report suspected cases to those authorities trained to assess the individual and situation. This needs to be done without further endangering the older patient or risking loss of access to that individual [5]. In many cases, the optimal solution is not to remove the elderly person but to treat the abuser's underlying social and psychological problems, retaining the family unit and allowing the older patient to remain at home [9].

Elder Abuse Resources (Adapted from Aravanis [2] and Kleinschmidt [9])

- Hotlines, 24 h: available in most states
- Social services
- Adult Protective Services or Department on Aging: Are state run with legal responsibility and authority to investigate complaints and provide services for elder well-being
- Law enforcement officials
- National Center on Elder Abuse
  202–682–2470, 202–898–2586
  Fax 202–898–2583
  http://interinc.com/NCEA
  NCEA@nasua.org
  www.elderabusecenter.org
  1201 15th Street, NW, Suite 350
  Washington, DC 20006
- Long-Term Care Ombudsman Program: A federally legislated program for reporting suspected abuse of institutionalized patients
- Medicaid Fraud Control Unit: Run by the state attorney general's office, required by federal law to investigate and prosecute provider fraud or elder abuse in facilities receiving Medicaid funding

Elder abuse is recognized as a serious and ongoing social and medical issue on both national and international levels, leading to increased awareness of and interest in diagnosing, treating, and preventing adult abuse. The 2015 White House Conference on Aging (WHCOA) listed it as a top priority and an item to be readdressed at future WHCOA. Rates vary in studies from 7.6% to 11% and are generally felt to be 10% of the US population age 60 and older, translating to 5,600,000 victims in the United States. Rates are 3–5 times higher in cases of dementia, applying to dementia found in both the abused and the caregiver. The WHCOA used the US Department of Justice and Department of Health and Human Services 2014 Elder Justice Roadmap, as well as scientific studies of abuse, recognizing elder mistreatment as a widespread, serious problem in the United States. They have committed to research extending the understanding of elder abuse, providing direct services for patients and for training, and developing social policy to help decrease the prevalence of elder abuse [16].

Elder abuse is recognized by the World Health Organization as a violation of the right to be safe and free from violence [14].

Abuse and self-neglect affect the various systems of care, including local readmissions, state social services, and national public health. The patient is the central and enduring component of all of these various systems of care. Currently, one in five Medicare recipients discharged from the hospital is readmitted within 30 days, and preventable readmissions cost US$25 billion annually. The CHAP study by Dong suggests that without influencing the rates of patient self-neglect, and intervening when this is identified as a health risk, we will be hard-pressed to meet the Medicare goals of a 20% decrease in readmission in elderly patients as required in the Affordable Care Act [15].

Elder abuse is a recognized problem not just in the United States but in other developed and developing countries as well. Skirbekk and James studied a population age 60 and older from 7 of the oldest states in India and found similar rates of elder abuse and neglect (11%) as estimated in the United States (10%). They found that increasing levels of education serially decreased both all abuse and also the subsets of abuse studied (physical, verbal, economic, disrespect, and neglect). Eight or more years of formal schooling were associated with a statistically significant decrease in abuse. This paper suggests that the system of care for adult abuse extends outside of the medical systems of care and supports the provision of education to all [17].

This case description encompasses the entire system of care in an elderly patient with an open globe. The system of course goes beyond the traditional "doctor-patient relationship" and includes the outside emergency department, physician, and referring, consulting, and treating ophthalmologists; the university emergency department, physician, nurses, and the rest of the ophthalmology staffing team; the internal medicine, radiology, neurology, and oculoplastic services; physical and occupational medicine, social work, and skilled care nursing; as well as the dietary, nursing, and custodial services for the inpatient ward. The system of care is a network involving everyone who participates in a patient's care and thus also included the patient's family, her primary care practitioner, her insurance entity, and their insurance regulations. Each member of this extensive healthcare team provided a unique and valuable contribution. It is up to the admitting physician to help the patient to navigate the system for the best care. Doing so interweaves the competencies of communication skills and patient-centered care, professionalism, and clinical knowledge, maximizing the best use of resources without compromising care.

Case Resolution

After consultation with the children, they preferred to defer the large-volume tap and possible subsequent shunt procedure and request that neurology not further address NPH directly with the mother. The clinician explains that because their mother is considered mentally competent, she must be legally allowed to make her own medical decisions. The family discusses their concerns with the patient, and she elects to pursue follow-up care with neurology

after physical rehabilitation. She is presented with the evaluation from physical therapy and finally agrees she is unable to navigate her own house. She is willing to be admitted for skilled care and rehabilitation with the goal of returning home. Her family, though individually busy, agree to visit with her on a rotating basis providing adequate oversight. This scenario demonstrates an example of self-neglect and the absence of an identified family caregiver or group family caregiver mentality. Social intervention is able to redirect the patient and her family, allowing her to return eventually to her own home once it is modified for an elderly individual.

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