Chapter 11
Elder Abuse

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Elder Abuse

The World Health Organization defines elder abuse as a single or repeated act, or lack of appropriate action, that causes an older person harm or distress within any relationship in

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which there is an expectation of trust [30]. Elder abuse, also known as elder mistreatment, can be subdivided into five categories: physical abuse, psychological or emotional abuse, sexual abuse, financial exploitation, and neglect (caregiver and self-neglect). Nationwide, there is a 10% prevalence rate for elder abuse; however, most prevalence measurements rely heavily on self-reported data, leading researchers to believe that this number is likely underestimated [14]. It is estimated that for every case of elder abuse reported, 23 cases of elder abuse remain unreported [2]. Older adults who are more advanced in age, or mentally impaired such as suffering with dementia, socially isolated, or disabled in some way, are at a higher risk for experiencing elder abuse [21]. Addressing the gap in healthcare professionals' reporting of elder abuse is critical to the health and safety of the older adult population, as elders who experience abuse have a 300% higher risk of death [9].

As the baby-boomer generation ages and life expectancy in the United States continues to increase, the size of our elder population age 65 and older continues to rapidly expand, growing from 13.7% of the population in 2012 to an estimated 20.3% by 2020 [22]. Despite this shift to an older demographic, elder abuse research is still relatively lacking, remaining in the early stages of development. For example, despite the existence of several screening tools, identifying mistreatment is challenging because of their inconsistent use of criteria or lack of use of criteria for labeling behavior as abuse. In the remainder of the chapter, case scenarios appear in italics after the discussion for types of elder abuse.

Caregiver Neglect

The most prevalent type of elder mistreatment is neglect, with a reported one-year prevalence of 5.9% [1]. Caregiver neglect is defined as the failure of a designated caregiver to meet the needs of a dependent elder [24]. Clinically, we define a caregiver as a person in a trusting relationship with an elder who has assumed responsibility for his/her care. Abandonment,

defined as "leaving an elder alone without planning for his or her care" [21] i.e. food, clothing, and shelter, is considered a form of caregiver neglect.

Mr. A, a widowed man in his late 70s, was brought into the emergency room by a neighbor who found him disoriented and wandering in the neighborhood. Upon examination, Mr. A was found to be underweight and dehydrated. He was oriented to his name only. He was unable to provide any medical history and was somewhat irritable during the interview.

The emergency room team learned that Mr. A had been diagnosed with dementia a few years earlier and that his family was responsible for his care. They were able to contact his son, who lived in a separate house in the same neighborhood as Mr. A and was the designated caregiver. Mr. A's son would come to check on Mr. A daily after he got off work and make sure that there was enough food in the house. Mr. A was home alone for most of the day. On the basis of the information provided, it appeared that Mr. A's level of care and supervision were inadequate given the extent of his cognitive deficits. The emergency room team explained to the family that Mr. A required 24-hour supervision to maintain his health and safety. They also called Adult Protective Services (APS) for concerns about neglect by Mr. A's son (as the designated caregiver).

Mr. A was admitted to treat his dehydration. During the admission, the team social worker met with Mr. A's son and worked to improve the level of care for Mr. A. The family was thankful for the education and assistance and worked with APS to secure the necessary resources to ensure that Mr. A could remain at his home with appropriate level of care.

Self-Neglect

Self-neglect is defined as the inability of an elder to perform essential self-care. Self-neglecting behavior can be due to physical or mental impairment, as well as any form of diminished capacity [16]. It can be more challenging to identify in a clinical setting because healthcare professionals are tasked with determining several factors, including whether the

behavior is a recent development or part of a life-long pattern of behaviors and whether the elder has full decision-making capacity [25].

APS received a call regarding Mr. B, a 77-year-old man, who lives alone in his home. His neighbor reported concern for the state of his home, stating that there was rotten food in the fridge, no electricity, and an apparent roach infestation.

APS responded to Mr. B's home and met with Mr. B. He claimed that he was fine on his own and did not need assistance. Mr. B wanted to continue living at home. On the basis of the caseworker's clinical interview, Mr. B was oriented to self and place only. He could not explain how he procured his food, or paid his bills, or discuss any of his medical conditions or treatments. He was malodorous with soiled clothing. The house was found to be as described by the neighbor. Based on the evaluation, there was grave concern for self-neglect and Mr. B's imminent safety.

Financial Exploitation

Financial exploitation, another form of elder mistreatment, is defined as the illegal or improper use of an elder's resources for monetary or personal benefit [11]. Financial exploitation can include actions such as altering a will or life insurance policy without permission, taking someone's social security or retirement benefits, forging checks, and using someone else's credit card or bank account [21]. Financial exploitation is among the more common forms of elder mistreatment, with a one-year prevalence rate of 5.2% [1]. Financial exploitation can have severe consequences, costing adults 65 years and older approximately $36.5 billion per year and causing one in ten victims to turn to Medicaid as a result of having money stolen from them [15].

Ms. C, an 84-year-old woman, had been diagnosed with cancer earlier in the year and had asked her daughter to assist with her finances, as she no longer had the energy to take care of them. Ms. C's son visited her months later and noticed that there were a number of unpaid bills, including those for her utilities. His mother also noted that her daughter had asked her

to sign a check for $50,000 as a "loan" to the daughter. Ms. C's son became concerned about his mother's financial welfare and immediately contacted APS to report his findings.

An investigation was opened. APS discovered that the daughter had been using her mother's accounts to pay off her own home and for other personal expenses, depleting her mother's savings. Working with Ms. C, her son, and local courts, APS was able to secure her accounts and establish her son as the responsible person for assisting his mother with her finances.

Physical Abuse

Physical abuse is defined as the willful infliction of physical force on an elder that could result in physical injury, pain, or impairment. Forms of physical abuse can include hitting, biting, kicking, pinching, forceful administration of drugs, force-feeding, physical punishment, or physical restraining of an elder [19].

Ms. D is a 72-year-old woman who recently remarried after her husband passed away several years ago. One of her sons flew into town to visit her for the weekend while her husband was away. While visiting her, Ms. D's son noticed bruising on his mother's arms and temple and thought she seemed quieter than normal. She said, "Everything is fine," when he asked her about any physical altercations or abuse.

The next day, due to his concern, Ms. D's son took her to a clinic for a physical examination by her long-standing physician. The physician found several more bruises on Ms. D's torso. With prompting, Ms. D revealed that her husband had become physically aggressive in the last six months. She had been too ashamed to share this with her physician or family. Ms. D's physician contacted APS. Ms. D was admitted to the hospital for further evaluation of her physical injuries.

Sexual Abuse

Sexual abuse is defined as nonconsensual sexual contact of any kind with an elder person, which can include acts such as

unwanted touching, rape, sexually explicit photographing, and coerced nudity [19]. It is the least common form of elder mistreatment, with a one-year prevalence rate of 0.6%, although some states group sexual abuse with physical abuse, which could lead to slightly lower nationwide sexual abuse rates [1, 28]. Within group homes, perpetrators may not only be employees but also possibly other residents, often due to the prevalence of cognitive impairment disorders among those populations.

After admission, a complete physical examination was performed on Ms. D. Further evidence of abuse was discovered in the form of bruising on her inner thighs and vaginal tenderness. After the examination, Ms. D revealed that when intoxicated, her husband had been forcing her to have sex. She was not comfortable with the physician's sharing this information with her children.

The inpatient social worker and APS caseworker met with Ms. D to discuss steps to take to maintain her safety. In consultation with her children, she decided to move in with her daughter, who lived in a neighboring town.

Psychological Abuse

Psychological abuse, also known as emotional abuse, involves the infliction of anguish, pain, or distress through verbal or nonverbal acts, including insults, threats, intimidation, humiliation, harassment, or isolation [19]. It can occur in isolation or in conjunction with other forms of abuse. It is one of the more difficult forms of abuse to detect because it lacks the clear physical evidence seen with other abuse cases [10].

Mr. E is an 88-year-old man whose family recently moved him into an assisted-living facility after a fall at home, where he lived alone, several months ago. They were concerned about his safety living alone and discussed his moving into a more supported setting. Mr. E agreed and selected his new home with his family.

On a visit to their father, Mr. E's children noticed that he seemed withdrawn and was not eating as well. During the visit,

Mr. E avoided eye contact and seemed depressed. When speaking to his children about how he had been faring at his new home, he seemed reluctant to talk about his experiences, causing the children to become even more concerned. His children started visiting more often and encouraging Mr. E with meals and activities. They noticed that he would brighten up when they were together, but toward the end of the visit, he would appear more anxious and depressed. His daughter also noticed that her father seemed especially uncomfortable around one of the staff members. She asked her father directly about his interactions with the staff member. After much reluctance, he stated, "I don't want to make trouble" and revealed that the staff member was very harsh toward him, often berating him with statements such as "You're trying to make my job harder," or even blaming him for malfunctioning equipment.

The family informed the assisted-living facility management, which completed a swift investigation and removed the staff member. Soon after the staff member's dismissal, Mr. E's mood and activities improved. He was more social, eating better, and enjoying the services provided at the assisted-living facility.

Risk Factors of Elder Abuse

When working with older adults, it is important to keep in mind risk factors that make certain individuals more vulnerable to abuse. On the basis of a variety of studies, older adults who are more at risk to be abused share the following characteristics [13].

General Risk Factors

General risk factors include the following:

- Low income or poverty
- Diagnosis of dementia
- Experience of previous traumatic events
- Functional impairments

- Behavioral problems
- Living with a large number of household members
- Low social support

Financial Exploitation

Peterson et al. identified the following factors to be associated with risk of financial exploitation of older adults [23]:

- Nonuse of social services
- Need for assistance in activities of daily living
- Poor self-rated health
- No spouse/partner
- Non-Caucasian older status (in particular this risk was found to be significantly higher among African Americans)

Perpetrators

Though there are limited data, perpetrators are most likely to be as follows [14]:

- Adult children or spouses
- Men
- Socially isolated individuals
- Unemployed or having financial problems
- Experiencing major stress

They are also more likely to have the following:

- A history of past or current substance abuse
- Mental or physical health problems
- A history of trouble with the police

Assessment of Elder Abuse

Currently, there are no national standards stipulating how clinicians should assess for potential elder abuse. There are a variety of reasons for the absence of standards. These include

no widely accepted screening tools, varying definitions of abuse and laws regarding reporting of abuse, and uneasiness of physicians with reporting abuse. Based on these concerns, the US Preventive Services Task Force (USPSTF) concluded that, "The current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults of abuse and neglect" [29]. However, the USPSTF noted that the potential harm of screening may also be small (shame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results were provided as potential harms). Though the USPSTF does not recommend screening, a number of professional organizations do recommend routine screening. For example, the American Medical Association, which includes elder abuse under the rubric of family violence, recommends that physicians "routinely inquire about the family violence histories of their patients" (AMA Policy Family Violence-Adolescents as Victims and Perpetrators H-515.981).

On the basis of a 2004 review of available screening tools for elder abuse, Fulmer et al. [12] noted that, while there is no one ideal scale, it is important that physicians create a system to implement in their practice. Yaffe et al. [31] recommended the use of the Elder Abuse Suspicion Index, which provides the physician with questions that could raise the concern for elder abuse. It is not a diagnostic tool but one that prompts the physician to enquire about abuse in greater detail. One complicating issue related to assessing for abuse in older adults is the impact of cognitive disorders. Many with cognitive deficits may not be able to provide the information needed during the assessment. While it is commonplace to include family members and caregivers in older-adult care, this, too, may not always be adequate in the setting of elder abuse when the perpetrator is a family member or caregiver, in cases of suspected abuse, it is very important to meet with the patient and family or caregiver separately. Based on a number of recommendations in the literature, questions in Table 11.1 could help identify elder abuse. When asking these questions, it is important to look at nonverbal communications (e.g., eye contact).

Table 11.1 Questions to help identify elder abuse

Physical abuse
Has anyone hurt you?
Has anyone threatened you?
Do you feel safe at home?
Psychological/emotional abuse
Has anyone shouted at you?
Has anyone stopped talking to you because they were angry with you?
Do you ever feel alone when your family/caregiver is near?
Has anyone been mean to you?
Do you feel that you will be punished if you disagree with your family/caregiver?
Neglect
Do you have enough food and medications?
When you need something (e.g., clothing, dentures, or eyeglasses), do you have a way of getting it?
Do you have a plan for getting urgent needs met?
Financial abuse
Have you signed any forms that you did not understand?
Have you been forced to sign any forms related to money?
Has access to money or assets been taken away from you?
Sexual abuse
Have you been forced to perform sexual acts against your will?
Do you worry about being sexually violated?

Along with an appropriate history that collects information regarding nutrition, injuries, and treatment adherence, a complete physical examination is critical to assessing for physical abuse. Objective findings of abuse, particularly, physical, sexual, and neglect, can be gleaned from a physical examination. Common findings for physical abuse include

injuries to areas that are usually not affected by accidental injuries, e.g., the inner thighs, unexplained fractures, or traumatic alopecia. Sexual abuse may present with intraoral injuries such as that of the palate, vaginal or anorectal bleeding, or injuries secondary to restraints. Neglect can present with unexplained weight loss (inadequate nutrition), poorly controlled medical conditions (nonadherence with medications), or ulcerations in atypical locations, suggesting improper or forced positioning causing undue stress on the musculoskeletal system [5].

Finally, it is important for the examining physician to differentiate common findings in older adults (whether it is because of aging or common medical illnesses) from abuse. Examples include dermatological findings such as senile purpura, nosebleeds and rectal bleeding (from internal hemorrhoids), and dehydration (from reduced thirst sensation).

Interventions for Elder Abuse

Situations in which elder abuse is suspected or identified require the clinician to intervene appropriately. If there are emergent medical situations, for example, acute injuries, serious safety risk, or metabolic instability, immediate inpatient care may be warranted. If possible, clinicians may involve family members or caregivers to devise a safety plan whereby the older adult's health can be safeguarded. As described in later sections in the chapter, healthcare providers also have an obligation to report suspected and identified elder abuse to APS and, possibly, to legal authorities. Depending on the immediate resources available, the medical team can work with the agency and caregivers to create a treatment plan.

Legal Services and Policies

Older Americans Act

The Older Americans Act, passed by Congress in 1965, is a major vehicle for providing support to assist older adults with

maintaining their independence in their own homes and communities. Although a large component of the funding is allocated to nutrition and social services such as congregate and home-delivered meals, assistance is also provided for transportation, legal services, caregiver support, community service employment for low-income elderly, training, research, development projects in the field of aging, and vulnerable elder rights protection activities. The Act authorizes service programs to accomplish these tasks through state and Area Agencies on Aging [20]. The Act also established the US Administration on Aging to work closely with Area Agencies on Aging and administer federal programs, such as the National Center on Elder Abuse, which provides elder-abuse awareness and education [3].

Over the years, reauthorization of the Older Americans Act, as recently as 2016, has included provisions that aim to protect vulnerable elders, such as in-home services for the frail elderly; the long-term care ombudsman program; assistance for special needs, health education, and promotion; prevention of elder abuse, neglect, and exploitation; elder rights and legal assistance; and benefits outreach, counseling, and assistance programs [20].

Elder Justice Act

The Elder Justice Act, the first comprehensive legislation to address elder abuse, was signed into law by President Obama on March 23, 2010, as part of the Patient Protection and Affordable Care Act. The aim was to develop and implement strategies to decrease the likelihood of elder abuse, neglect, and exploitation. The Act authorized federal funding for state and local APS programs, support for the Long-Term Care Ombudsman Program, Elder-Abuse Forensic Centers, an Elder Abuse Coordinating Council for federal agencies, and an expert public Advisory Board on Elder Abuse, Neglect and Exploitation, and requires the reporting of crimes in long-term care facilities to law enforcement. At present, Congress has not appropriated funds for the implementation of the Elder Justice Act [18].

Adult Protective Services (APS)

APS are social service agencies that were first formed in the mid-1970s with the passage of Title XX of the Social Security Act [6]. By the early 1980s, every state and/or local government had an agency in its own jurisdiction. APS is responsible for receiving and investigating reports of suspected abuse, neglect, and exploitation. APS staff perform a home visit with the alleged victim, generally within 24–72 hours, to determine whether he or she needs protection and has decision-making capacity to accept or refuse protective services. If warranted, APS will arrange or refer the victim to other services. Other services may include financial management, food or meal delivery, health care, home repair or cleaning, housing (emergency or long term), legal assistance, transportation, and victim assistance and compensation [26]. All states have APS statutes that authorize and regulate provision of services in cases of elder abuse. A few states have both an APS agency and an elder protective service agency that provides services to adults 60 years of age and older [8].

State law governs what types of elder abuse and what categories of victims an APS agency may investigate. State APS statutes may contain eligibility criteria about the following:

- Age: Most states cover persons age 18 years and over, while others cover persons age 60 years and older or 65 years and older.
- Condition: In a majority of states, an individual must have some sort of condition, such as "mental or physical impairment," "mental or physical illness," "mental retardation," "developmental disability," "dementia," or "substance abuse."
- Function: In some states, a person must have impaired ability to do certain things, such as provide self-care; manage finances; protect him/herself; obtain services; or make, communicate, or implement decisions.
- Assistance needed: A few states stipulate that an individual must have no able and willing person available to provide assistance.

- Living situation: In some states, APS will investigate only when a person lives in a house or apartment. Reports made about residents in institutions such as a nursing home are investigated by another agency, such as the long-term care ombudsman program.
- Guardian or conservator: In some states, an individual is automatically eligible for APS if a court has ruled that the person lacks decision-making capacity and has/will appoint a guardian or conservator for that person [26].

A comparison chart [27] on provisions in APS laws by state may be found at: https://www.americanbar.org/content/dam/aba/administrative/law_aging/Abuse_Types_by_State_and_Category_Chart.authcheckdam.pdf

Mandatory Reporting

Most states have a statutory requirement to report elder abuse, neglect, and exploitation. Reporting requirements vary from state to state and are typically in the state's APS laws. In most states, reporting suspected abuse is mandatory for healthcare and social service providers and law enforcement officers. Some states require bankers and other fiduciaries, or any member of the community, to report suspected elder abuse [17]. Failure to report abuse is usually considered a misdemeanor and may be grounds for a fine, imprisonment, loss of license, or other disciplinary action by an employer or a licensing board. Most state APS laws protect the identity of the reporter and provide immunity from criminal, civil, or administrative liability to persons who report abuse or participate in activities stemming from a report [4].

Once APS receives a report, a service specialist conducts an investigation and develops a plan that continues until the case is resolved, or reasonable efforts are made. APS operates under the "least restrictive alternative" philosophy, meaning service specialists identify interventions with the least restrictions on the victims. For example, if an older adult is experiencing difficulty managing his/her finances, someone can make a recommendation for financial counseling. Depending on the situation,

a more restrictive option may be needed, for example, to obtain a payee service. In an effort to maintain autonomy and ensure least restrictive alternatives, a victim of abuse may decline APS services if he/she has decision-making capacity [7].

Conclusions

Elder abuse has a fairly high prevalence, despite being underreported. Given the serious impact of abuse on older adults, clinicians should remain vigilant for warning signs of elder abuse and be knowledgeable of the assessments and interventions necessary to address suspected elder abuse.

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