



# Elder Abuse

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# Relevance

- The Changing Demographic
  - Old people are everywhere!
  - % of earth's population older than 65
    - 1900: 1% (15 million)
    - 1992: 6% (342 million)
    - 2050: 20% (2.5 billion)
  - Life expectancy in United States is 77.4 years

# Scope of the Problem: Elder Abuse

- Exact incidence unknown (under-reporting)
  - 84% cases are NOT reported (5 of 6 cases)
- 75% EDs w/ protocols for child abuse, 27% have elder abuse protocols
- Up to 5% of community-dwelling elders in the US are victims of maltreatment (2004)
- 1<sup>st</sup> case described in 1975: “granny battering”
- Related literature in various journals
  - emergency medicine, social work, law, dentistry, pathology, palliative care, orthopedics, insurance

# What is Elder Abuse?

- Elder Mistreatment
- Elder Maltreatment
- Inadequate Care  
of the Elderly

Independent risk factor  
for increased mortality



# Self Neglect

- Distinct from elder abuse, but clinician should be aware
- Diogenes Syndrome
  - Greek Cynic, rejected material comfort & hygiene, lived in a barrel (although social)
  - Characteristics
    - Domestic squalor
    - Social withdrawal
    - Tendency to hoard garbage
    - Lack of shame
    - Refusal to accept help
  - Underlying pathology: likely lifelong sub-clinical personality disorder → progresses to gross neglect

# What is Elder Abuse? (AMA 1987)

- Acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult
- Mistreatment of the elderly person may include physical, psychological, or financial abuse or neglect, and it may be intentional or unintentional.
- Abuse includes the intentional infliction of physical or mental injury; sexual abuse; or withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person by one having the care, custody, or responsibility of an elderly person.

## Elder mistreatment: Categories and definitions

### Physical

Willful act carried out with the intent of causing pain or injury

Examples: slapping, hitting, kicking, force-feeding, restraint, striking with objects

### Emotional

Willful act executed to cause emotional pain, injury, or mental anguish

Examples: verbal aggression or threat, threats of institutionalization, social isolation, humiliating statements

### Financial

Misappropriation of an elderly person's assets for personal or monetary gains

Examples: theft of checks or money, or coercion to deprive the elderly person of his or her assets, such as forcible transfer of property

### Sexual

Nonconsensual sexual activity with an elderly person

Examples: suggestive talk, forced sexual activity, touching, fondling with a nonconsenting competent or incompetent person

### Caregiver neglect

Intentional or unintentional failure of designated caregiver to meet needs necessary for elderly person's physical and mental well-being

Examples: failure to provide adequate food, clothing, shelter, medical care, hygiene, or social stimulation

### Miscellaneous

Violation of rights

Examples: abandonment, denial of privacy or participation in decision-making

**73% cases  
≥1 type of  
victimization**

ADAPTED FROM KRUGER RM, MOON CH. CAN YOU SPOT THE SIGNS OF ELDER MISTREATMENT? POSTGRAD MED 1999; 106:169-183.

# **Risk factors for elder abuse**

## **Elder-specific**

- Cognitive impairment
- Poor health and functional impairment
- Social isolation
- Shared living arrangement
- Dependence on caregiver

## **Caregiver-specific**

- Substance abuse
- Mental or physical illness
- Financial dependence on the victim
- Stress (divorce, bankruptcy, caregiver burden—in some studies, but not all)
- History of violence

COMPILED FROM KRUGER RM, MOON CH. CAN YOU SPOT THE SIGNS OF ELDER MISTREATMENT? POSTGRAD MED 1999; 106:169–183.



## **Physical findings that suggest elder abuse or neglect**

### **General appearance**

Poor hygiene, dirty clothing

### **Vital signs**

Low blood pressure, rapid pulse (may indicate dehydration, blood loss, risk of falls)

### **Oral cavity**

Ecchymosis (may indicate forced oral sex), cigarette burns on the lips and fingertips, tooth fractures, ill-fitting dentures, oral venereal lesions

### **Ear, nose, and throat**

Deviated nasal septum (from repeated trauma), finger imprints or rope marks around the throat

### **Eye**

Subconjunctival or vitreous hemorrhage (may indicate new trauma), retinal detachment, orbital fractures, and traumatic cataracts (may indicate old trauma)

### **Skin**

Burns, lacerations, ecchymosis, pressure ulcers, bruises in various stages of healing, lesions suggestive of use of restraints on the extremities, immersion burns (glove-stocking distribution)

### **Chest and abdomen**

Rib fractures, pneumothorax, splenic rupture, and intra-abdominal hemorrhages (may be manifested as Cullen or Turner signs)

### **Nervous system**

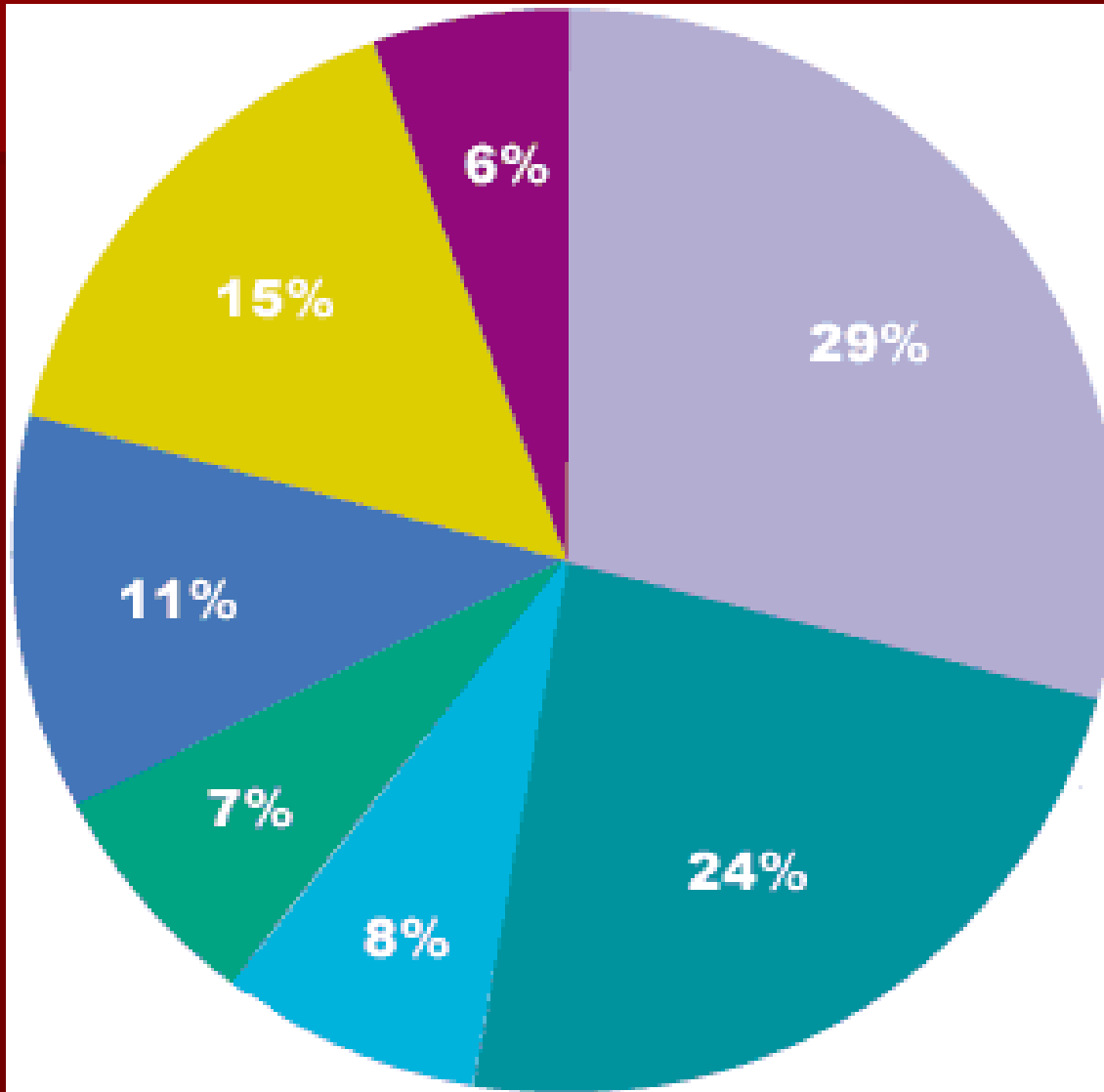
Focal findings on examination, impaired mental status, impaired function, depression, anxiety

### **Orthopedic**

Impaired gait, leg length discrepancies due to fracture

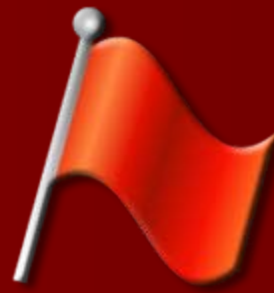


# Relationship of Abuser



- Son
- Daughter
- Spouse
- Grandchild
- Multiple Family members
- Other Family
- Friend

# Red Flags



- Caregiver resistant to leave patient alone w/ HC provider
- Poor knowledge of patient's medical conditions
- Missed appointments/ frequent visits ED/ doctor's office
- Delay in seeking medical care, esp for injury or fall
- Doctor shopping
- Discrepancy objective data & caregiver account
  - Ex. neg UDS pt on narcs, caregiver says giving meds
- Different histories given by caregiver & patient
- Patient's history seems rehearsed
- Patient appears fearful, tentative, cautious with caregiver
- Unexplained injuries
- Romantic involvement w/ ~newcomer
  - esp if much younger, or new after death of spouse

# Institutional Elder Abuse

- Mistreatment that occurs in nursing homes and other living facilities
- Forms of abuse are same
- Perpetrators
  - staff members, other residents, and visitors

# Institutional Elder Abuse

## ■ Characteristics of Abusive Staff Members

- Younger
- Less educated
- Less experience in working in a nursing home environment
- Dissatisfied with their jobs

## ■ Institutional Risk Factors

- Stressful working situation
- Staff “burnout”
- Low wages
- Lack of training in conflict resolution

NH admin should report abuse promptly,  
not wait until internal investigations are completed.

# Barriers to Reporting

Physicians report only 2% cases

- Uncertainty about the validity of the diagnosis
- Lack of training in recognizing abuse
- Lack of awareness of the prevalence of abuse
- Discomfort in confronting the alleged perpetrator
- Fear abuser will retaliate against the victim
- Unaware of procedures for reporting
- Lack of understanding of the role & function of APS
- Disinclination to be involved in the legal system

# Role of the Physician

- Screen routinely for possible mistreatment
- Interview patient alone
  - “Do you feel safe at home?”
  - “Who cooks for you?”
  - “Do you get help with shopping when you need it?”
  - “Do you have to wait a long time for your food or medicine?”



# Role of the Physician

- Establish rapport with caregiver and make inquiries in a non-judgmental way
  - “You’ve been carrying a heavy responsibility for some time now, and it’s alright to feel burdened at times...”
- Consider unintentional neglect resulting from the failing health of the caregiver

# Role of the Physician

- Documentation: clear and legible
  - may become evidence in a court of law
- Draw or photograph physical exam findings that are consistent with abuse
- Remember the goal is not to punish the victim or the abuser, but to **stop further abuse**

# Intervention

- Physicians should report suspected abuse to APS
  - There is no burden of proof for the physician
- If patient is in immediate danger, then remove from the situation
  - Transfer care to reliable friend/ family member
  - Admit to hospital
  - Emergency shelter referral
  - Police

# Intervention & Prevention



- Home health services
- Adult day care
- Home visit program
- Social activities
- Pastoral visits
- Social service resources
- Respite care
- Caregiver training
- Support groups
- Assistance from family/friends

# Refusal of Intervention

- Most elders want the abuse to stop, but they also want their families to remain intact, & they want to feel safe at home for their remaining years
- Physicians should establish mental capacity to make decisions
  - If capable, provide info about resources and emergency shelters
  - If incapable, guardianship may be required

# Ms. T's Case



# Ms. T's Case

- 79 yo female Ms. T is brought to the doctor's office by her son, with whom she lives.
- PMH: severe osteoporosis c/b several compression fractures, w/ chronic pain control
- Son reports she was highly functional and independent, but not for the past year.

# Ms. T's Case

- Son appears very concerned about her health and functional status
- He answers all her questions for her
- When asked to leave the room so that the patient can be examined, he refuses, saying that she would be afraid if left alone in a new place



# Ms. T's Case

- Ms. T's appearance is unkempt and her clothes dirty.
- In the course of discussing the mgm't of Ms. T's clinical situation, the doctor offers help in the form of home health services, but the son refuses.

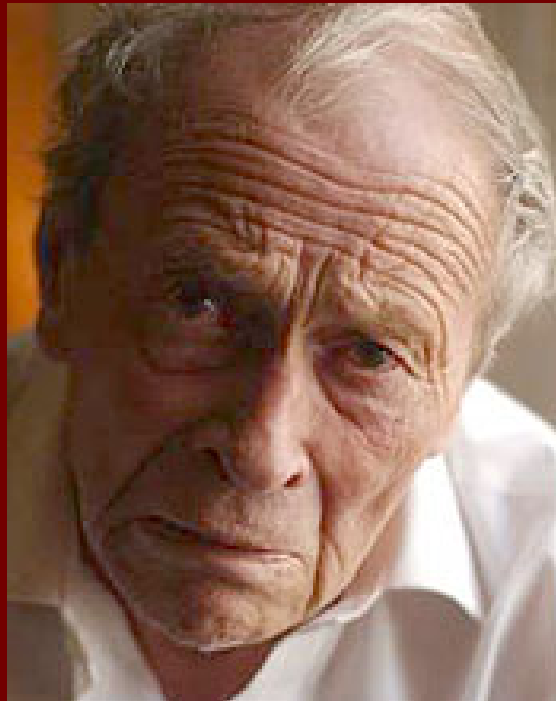


Thoughts?

# Ms. T's case resolution

- Mrs. T's son was simply overwhelmed.
- Caregiver burnout
  - Did not have resources & support to care for her and didn't know who to ask.
  - Initially, reluctant because he viewed his inability to care for her as a failure.
- Outcome: PCP gained son's trust through home visits, & he eventually allowed home health services to come in and assist him.

# Mr. A's Case



# Mr. A's Case

- Mr. A is a robust and healthy 70 yo retired widower; followed in a geriatric clinic
- PMH: HTN, CVA w/ complete functional recovery, mild depression
- He missed several clinic visits over a 4 week period and hadn't contacted his children in 2 weeks

# Mr. A's Case

- Without contacting his family, he came to ED p/w "syncope" & fall down the stairs → serious trauma to arms, chest, legs
- He c/o vague atypical chest pain, not associated with exertion; he had no prior hx of symptomatic CAD

# Mr. A's Case

- He underwent the standard chest pain drill in the ED along with a head CT.
- His head CT was normal.
- EKG, normal, but troponins +, rising
  - Diagnosed: NSTEMI
  - ASA,  $\beta$ B, heparin, IIb/IIIa inhibitor
  - Admitted for cardiac cath

# Mr. A's Case

- His PCP consulted to assist in his mgm't.
  - Noted inconsistencies in his history and examination
  - Noticed Mr. A was apprehensive, avoided eye contact, and seemed ashamed about being admitted



# Mr. A's Case

- He had multiple bruises on his face, arms, legs, abdomen, and back all at **various stages of resolution**.
  - The arm injuries appeared to be defensive in nature
- Contusion in the shape of the sole of a boot on his chest.



Thoughts?

# Mr. A's case resolution

- PCP knew asked Mr. A to speak with his daughter and he agreed.
- Daughter: young man hanging around her dad's house to help him out
  - She was suspicious of the relationship between the two of them and thought the young man may have had something to do with what happened to her father.
- PCP asked Mr. A about the young man
  - Mr. A then told him that his children were unaware that he was bisexual. Wife died, explored more relationships with men, like the young man his daughter mentioned
  - Initially, relationship was good → young man stealing money and physically abusing him.
  - The two men argued money and the young man beat him and kicked him in the chest, down the basement stairs and left him there.
- Outcome: traumatic cardiac contusion presenting as NSTEMI.
  - Mr. A's PCP stopped the cardiac cath (since he didn't need it); police report filed and APS was consulted.

# Mr. K's Case



# Mr. K's Case

- 66 yo male brought to ED by a 36 yo female companion CC: progressive weakness, inability to perform ADLs without assistance.
- The woman stated that he had lost 35 lbs over past 2 yrs and has become progressively disabled.
- She claimed that he had refused to seek medical attention, despite her efforts to encourage him to do so.

# Mr. K's Case

- Mr. K was admitted for FTT
- Companion visited daily and was seen
  - screaming at him
  - physically assaulting him
  - eating food from his tray
- The intern felt uncomfortable discharging him, so the hospital's elder abuse team was consulted

# Mr. K's Case

- When the elder abuse team interviewed Mr. K, his female companion constantly interrupted and answered questions for him.
- Mr. K was clearly intimidated by her.
  - However, even after the woman left the room at the team's request, Mr. K still maintained that he wanted to go home with her.



Thoughts?



# Mr. K's case resolution

- Demonstration of the ambivalence common among the abused with respect to their abusers.
- He was a victim of physical abuse, emotional abuse, and financial exploitation.
- His abuser convinced him that he was debilitated and needed her to take care of him...otherwise he would end up in a nursing home...he had no one else.
- Outcome: While in the hospital he made drastic improvements in functional capacity such that he realized that he was in fact able to do most things for himself and didn't need her after all. This gave him the confidence to ultimately tell her (with the support of the elder abuse team) that he no longer wanted her living with him and caring for him. They helped him transition home with the assistance of home health/PT/OT. APS assisted him in getting the locks on the doors changed. He thrived in her absence.

# Ms. H's Case



# Ms. H's Case

- 76 yo female with debility secondary to dementia, osteoporosis with compression fractures, RA, and depression
- She is cared for at home by her adult daughter with the support of hospice nurses and aides.
- The hospice nurse contacted her physician and told her that the aide noticed large bruises on Ms. H's arms that were covered with cosmetics.

# Ms. H's Case

- When asked about the bruises and the cosmetics, the daughter stated that Ms. H had fallen and she covered the bruises with make-up because her mother didn't like the appearance of them.
- The hospice nurse was concerned about caregiver burden and the possibility of undiagnosed mental illness in the daughter. She arranged for Ms. H to spend 5 days in a nursing home so that her daughter could have respite.



Thoughts?

# Ms. H's case resolution

- Caregiver burnout → abuse.
  - Daughter caring for her w/o assistance >5 years.
  - frustrated and started taking her frustration out on Ms. H.
  - Hospice social worker had witnessed verbal abuse.
- PCP in NH: Ms H said daughter did not hit her, but she could be excessively rough during transfers; pinched her if she did something wrong
  - PCP offered stay at the nursing home indefinitely, but Ms. H said she wanted to go back home with her daughter.
  - Daughter 2 days later in NH and dc'd mom because NH could not care for her mom the way she could.
- PCP meeting with daughter, hospice nurse and SW.
  - All expressed concerns re: daughters burnout, affect on ability to care for mom
  - PCP told her that she would make a referral to the "Department of Social Services" (APS) to see if there were other resources available to assist her.
- Outcome: Shortly, Ms. H developed urosepsis → hospital, daughter stated she could no longer care for mom → NH → died w/in 2 weeks

# Ms. Z's Case



# Ms Z's Case

- Ms. Z is a 92 yo female who lives in an assisted living facility, however, her nephew's wife visits often and is very involved in her care.
- She presents to a physician 2 hours away to establish care because her "niece" is concerned about the quality of care she is receiving at the assisted living facility



# Ms. Z's Case

- According to Ms. Z and her “niece”, the assisted living facility did not administer her pain medications on time causing Ms. Z to get very nervous and start exhibiting signs of withdrawal. All her other meds were administered on time.
- Ms. Z is on a 75mcg fentanyl patch with prn Darvocet q 6 hours for breakthrough pain.

# Ms. Z's Case

- The patient and her “niece” are requesting that the physician provide them with back-up prescriptions for her pain meds just in case the pharmacy used by the assisted living facility delivers her pain medicine late again in the future.
- The “niece” reports that Ms. Z will be moving in with her in a few months and she will make sure that she gets all her medicines on time.



Thoughts?

# Ms. Z's case resolution

- Ms. Z's case is full of red flags.
- The PCP was very suspicious and called the facility and the pharmacy to verify the story.
  - It happened exactly as the patient's niece had said
  - NH did run out of fentanyl patch, patient did develop some w/d symptoms.
  - The family was trying to do what they could to prevent another occurrence of this.
- Outcome: things aren't always what they seem, but important to ask questions if there are red flags

# Summary

- Elder abuse is under-reported
- As the population ages, the prevalence of elder abuse will increase
- Elder abuse is an independent risk factor for mortality
- There are several different kinds of elder abuse and multiple types often co-exist
- In the community the perpetrator is most often someone with a relationship (family and/or financial) to the victim
- Physicians have a legal and ethical responsibility to report suspected abuse. The physician does not carry the burden of proof.

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