Identifying Elder Abuse in the Primary Care Setting

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Primary care physicians are in a unique position to identify and manage elder abuse in their setting. For an isolated older person, the physician may be one of the few contacts he or she has outside of the living arrangement. This article will summarize the various types of elder abuse, identify at-risk patients, and outline the physician’s role in screening, documentation, management, and reporting. Finally, a list of resources for both physicians and patients will be provided.

EPIDEMIOLOGY

The true prevalence of elder abuse is difficult to determine because there is great variation among states regarding what constitutes elder abuse. Conservative estimates indicate that 1.3% of the nation’s elderly are victims of elder abuse each year, with only one in 14 elder abuse cases reported to a public agency. Family secrecy, as well as a patient’s denial, fear, or shame, and the physician’s lack of awareness further lead to underreporting of elder abuse.

In 1996, Adult Protective Services (APS) departments investigated 364,512 reported cases of elder abuse. Of these cases, 43% were confirmed. By far, the most common form of reported elder abuse was neglect, accounting for 55% of cases, with physical abuse accounting for only 15%. Sixty-two percent of all cases involved abuse by other people, whereas 38% involved self-neglect. The perpetrator in 90% of the cases was a family member. The majority of victims are female (67%) and Caucasian (66%).

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DEFINITION

The American Medical Association defines elder abuse and/or neglect as “an act of commission or omission that results in harm or threatened harm to the health or welfare of an older adult.” Elder abuse may be intentional or unintentional and can be categorized into several types. Physical abuse involves the use of force that may result in injury, pain, or impairment. Physical abuse can also include the inappropriate use of drugs or restraints, force-feeding, and physical punishment. Sexual abuse is any type of nonconsensual sexual contact, unwanted touching, sexual assault, or battery (including rape, sodomy, nudity, and explicit photography). Emotional or psychological abuse is any verbal and/or nonverbal acts inflicting anguish, pain, or distress. This type of abuse may include verbal assaults/insults, threats, humiliation, and/or harassment. Treating an elder as a child and isolating the person from family, friends, or social activities are also forms of emotional or psychological abuse.

Neglect is the failure or refusal to fulfill a caregiver’s obligations or duties to an elder. This typically includes inadequate provision of food, water, shelter, clothing, hygiene, and/or medications, as well as safety and comfort. Financial exploitation is the misuse of an elder’s resources for personal or monetary benefit. Examples of financial exploitation include misappropriation of the elder’s income (eg, social security, pension, or dividend check); acquiring property or resources without the elder’s knowledge or consent; misusing a joint checking account; or obtaining money using the elder’s credit.

Finally, self-neglect poses a significant danger to an elder’s physical or mental health. Self-neglect occurs when an elder who is responsible for his or her own care can no longer provide himself or herself with adequate food, shelter, clothing, and/or medical or dental care.

WHO IS AT RISK?

There is a general lack of awareness among physicians regarding the risk factors for elder abuse, which decreases the chance of identification of such abuse. Although there is no definitive list of risk factors, there are several characteristics of both the victim and the abuser that should alert the physician to screen for elder abuse. Risk factors associated with the elderly that increase their potential for abuse include advanced age (over 75), increased dependency, social isolation, dementia, behavioral issues, depression, and incontinence.

An elder is also at a higher risk for abuse if he or she has a personal history of abuse or neglect as a child or a history of family violence. Alcohol use by either the elder or the caregiver is a risk factor.

Other caregiver risk factors include mental illness, drug abuse, lack of social support, and financial dependency. Competing caring demands from other family members (eg, an ill spouse or young children) also increase the likelihood of abuse. A personal history of family violence, specifically a history of childhood abuse by the caregiver’s father, is another risk factor. The more risk factors present, the higher the likelihood of abuse.

PHYSICIAN’S ROLE

All forms of elder abuse have the potential to affect the physical and emotional health of an older person. Although direct injuries from physical abuse are the most obvious, all forms of abuse can increase the risk for anxiety disorders, depression, and posttraumatic stress disorder. Neglect may lead
Physical Signs of Elder Abuse

<table>
<thead>
<tr>
<th>General</th>
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<tbody>
<tr>
<td>Weight loss</td>
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<tr>
<td>Dehydration</td>
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<tr>
<td>Poor hygiene</td>
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<tr>
<td>Head and neck</td>
<td>Traumatic alopecia; poor oral hygiene; absent or broken devices, such as hearing aids, dentures, or eyeglasses; subconjunctival or vitreous hemorrhage</td>
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<tr>
<td>Eye, ear, nose, and throat</td>
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<tr>
<td>Skin</td>
<td>Hematomas, welts, bites, burns, pressure sores, bruises</td>
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<tr>
<td>Genitourinary</td>
<td>Inguinal rash, fecal impaction</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Multiple fractures in various stages of healing; contractures in partially mobile or immobile patients</td>
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Answering for the patient, failing to offer assistance, or displaying indifference or anger. Other signs include failure of the caregiver to visit an elder who is hospitalized or being absent from an appointment for an elder with cognitive impairment.

Behavioral signs in the elderly patient can include fearfulness toward the caregiver, poor eye contact, or a hesitation to talk openly. Other indicators of possible abuse may include confusion, paranoia, anxiety, anger, or low self-esteem. The medical history should include a mental health screening, with particular attention paid to depression, anxiety, insomnia, and alcohol abuse. Assessment of functional dependence can be helpful in stratifying the elder’s risk for abuse, while evaluation for possible cognitive impairment is also important in assessing risk and competency. Physical signs that may signal neglect include contractures, subtherapeutic or supratherapeutic levels of medications, malnutrition, dehydration, and poor hygiene. Physical signs that may be caused by neglect or physical abuse are listed in Table 1.

**“RED FLAGS”**

During the primary care visit, behavioral and physical signs should raise suspicion for elder abuse. Behavioral signs on the part of the caregiver include insistence on being present for the entire visit.

**DOCUMENTATION**

Documentation should be precise and thorough because it may be used in guardianship hearings or possibly in criminal trials. Documentation begins with a description of the abusive event or neglectful situation, using the patient’s own words whenever possible. The duration, frequency, and severity of
the abuse should be recorded. The chart should include a complete medical history, a relevant social history, and a detailed description of any injury. If possible, photographs should be obtained of the injury. The assessment should contain the physician’s opinion as to whether the injuries were explained adequately. Documentation should also include any discrepancies between the elder’s and the caregiver’s accounts. Pertinent laboratory reports or radiographs should be included.\textsuperscript{5}

**MANAGEMENT**

Safety assessment is paramount in the management of elder abuse: the severity of the abuse should dictate the physician’s actions. Is the patient in any immediate danger? If so, acute hospitalization, safe home placement, and/or a court protective order may be indicated. Law enforcement, such as the local police department or sheriff, is especially helpful in cases of resistant, endangered elders, or family violence. There are a number of community resources and social support services that can help ensure patient safety. Multidisciplinary teams that include social workers and representatives from legal, financial, and adult protective services are integral to the management of elder abuse. Competency should be determined—if the patient is competent, he or she has the right to refuse intervention and to remain in an abusive environment. These patients should be given information on available resources in their community.

There are many reasons why elders may either deny that abuse is occurring or refuse services. They may fear retaliation, think that the abuse was deserved, or feel that nothing can be done. They may believe that they would not be able to stay in their home if it were not for the caregiver. In such cases, the physician should educate the patient about the available resources in the community and the potential consequences of abuse. If the patient lacks capacity, the physician should work with APS on options including guardianship, financial management resources, and orders of protection if indicated. Management should also include measures to decrease social isolation and caregiver stress. Interventions can include respite care, home health or homemaker services, counseling, and drug or alcohol rehabilitation.\textsuperscript{13,14,18}

**REPORTING REQUIREMENTS**

All 50 states have laws authorizing APS departments to intervene in cases of elder abuse. By contacting the state or local APS agency, a physician can determine the specific requirements of the respective state. Forty-two states have mandatory reporting of elder abuse. In the majority of states, health care professionals are identified as mandatory reporters. States vary as to what type of abuse (ie, physical, emotional, sexual, or financial) requires reporting. Mandatory reporting laws are controversial because they may come into conflict with a competent elder’s autonomy and with physician–patient confidentiality. In such cases, the physician should explain the legal obligation to report the abuse and emphasize that the goal of reporting is to gather information and develop a care plan to assist the elder. Additionally, many state statutes require health care professionals to report all incidents of elder abuse in long-term care facilities. All 50 states have a long-term care ombudsman to advocate on behalf of long-term care residents experiencing abuse. The name and contact number of the ombudsman are required to be posted in every rehabilitation and long-term care facility in the United States.\textsuperscript{5,13,19}
RESOURCES

There are many local and national resources for patients, caregivers, and physicians regarding elder abuse (Table II). Physicians who often serve as the front-line resource for educating families should become aware of the resources in the local community. Elderly persons and their caregivers can often benefit from a variety of services in the hopes of preventing such tragedies as neglect or abuse.

CONCLUSION

Elder abuse is an important public health issue that is underreported. Primary care physicians can play a significant role in the prevention, recognition, and management of elder abuse. Knowledge of the common behavioral and physical signs can guide the physician in identifying elders at risk and uncovering abuse that is not readily acknowledged by either the elder or the caregiver. APS is the legal authority for investigating reports of neglect or abuse in the home, community, or institutions. A multidisciplinary approach including the physician, nurse, social worker, and case manager, in addition to local and national resources, is integral to the management of elder abuse.