

Understanding elder abuse in family practice

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Abstract

Objective To discuss what constitutes elder abuse, why family physicians should be aware of it, what signs and symptoms might suggest mistreatment of older adults, how the Elder Abuse Suspicion Index might help in identification of abuse, and what options exist for responding to suspicions of abuse.

Sources of information MEDLINE, PsycINFO, and Social Work Abstracts were searched for publications in English or French, from 1970 to 2011, using the terms *elder abuse*, *elder neglect*, *elder mistreatment*, *seniors*, *older adults*, *violence*, *identification*, *detection tools*, and *signs and symptoms*. Relevant publications were reviewed.

Main message Elder abuse is an important cause of morbidity and mortality in older adults. While family physicians are well placed to identify mistreatment of seniors, their actual rates of reporting abuse are lower than those in other professions. This might be improved by an understanding of the range of acts that constitute elder abuse and what signs and symptoms seen in the office might suggest abuse. Detection might be enhanced by use of a short validated tool, such as the Elder Abuse Suspicion Index.

Conclusion Family physicians can play a larger role in identifying possible elder abuse. Once suspicion of abuse is raised, most communities have social service or law enforcement providers available to do additional assessments and interventions.

Case

Mrs B. is an 88-year-old widow who has been a patient in your practice for 27 years. She has stable ischemic heart disease and diet-controlled diabetes mellitus. You are concerned that her progressive hearing loss is interfering with her ability to comprehensively benefit from social contacts, but she resists repeated recommendations for audiology testing. You note to her that over time there has been marked deterioration in her short-term memory and suggestion of problems with judgment. She downplays these deficits and her current Mini-Mental State Examination score of 25 by insisting these are only "paper tests." When she ignores your advice to stop driving, you notify the motor vehicle bureau about your concerns.

In order to better understand Mrs B., you do an audit of her chart. You are reminded that 25 years ago you had assisted in getting her holiday respite care for her 85-year-old father. On Mrs B.'s return she found her father thin, dehydrated, and confused. The nursing home explained he had refused to eat and that communication with him had been limited because few of the staff spoke Spanish. Mrs B. had expressed dismay over her father's deterioration and the failure of the nursing home to contact her at the emergency telephone numbers she had provided.

Mrs B. currently lives alone and you have discussed with her that there are likely inadequacies in her food intake and that you are concerned about safe stove use. She has resisted these observations and your suggestion of a home visit assessment by a nurse or social worker. She does, however, consent to your proposal that you share your concerns with her only child, who lives about 2000 km away. The latter is difficult to reach by telephone, and voice messages you leave are not returned. When contact is eventually made, the daughter indicates she has adequate contact with Mrs B. through once-a-week telephone calls, and that her mother is a "normal 88-year-old" who requires no interventions.

Sources of information

MEDLINE, PsycINFO, and Social Work Abstracts have been searched annually since 2003 by one of the authors (M.J.Y.) for publications from 1970 onwards in English or French, using the terms *elder abuse*, *elder neglect*,

KEY POINTS Physicians working with older adults need to be aware of and sensitive to the signs of elder abuse. The Elder Abuse Suspicion Index is a validated tool for use by family physicians to help identify such abuse. Once there is a suspicion of abuse, physicians are encouraged to consult with adult protection or social services or with police officers trained in assessment of and response to mistreatment of older adults.



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elder mistreatment, seniors, older adults, violence, identification, detection tools, and signs and symptoms. Relevant publications were reviewed, acknowledging certain limitations. Specifically, it has been noted that the field of elder abuse research is “young,” comprising primarily descriptive, observational, and case studies, no meta-analyses, and only a few intervention trials.¹

Main messages

Elder abuse carries not only considerable morbidity, but also a surprisingly high rate of mortality not directly associated with specific acts of abuse.² Physicians working with older adults therefore need to be aware of and sensitive to what is interchangeably called *elder abuse, abuse of older adults, and mistreatment of seniors*. It is defined as single or repeated acts of omission or commission causing harm or distress to an older person, occurring within any relationship where there is an expectation of trust by an individual with responsibility for the care of a protected person as a result of a family relationship or who assumes responsibility for care of the person voluntarily by contract or ties of friendship.³ Elder abuse is distinct from random or incidental criminal acts aimed at older people by individuals outside such relationships. While mistreatment can occur as a result of ignorance, most elder abuse is believed to be nonaccidental or intentional.⁴ In some societies the word *elder* never appears in the definition of abuse of seniors, reflecting a practice of identifying any community leader as an elder, independent of age.

Identification of elder abuse. Identification of elder abuse is dependent on victims or on people commonly in a position to be alert or sensitive to mistreatment of older adults: bank employees, law enforcement personnel, home care workers, lawyers, notaries, nurses, social workers, psychologists, and physicians. While various professions approach elder abuse differently,⁵ family physicians are well positioned to see signs or symptoms suggestive of abuse, given that they see unique patients an average of 4 to 5 times per year.⁶ Despite this, physician reporting of elder abuse has been suggested to be the lowest among health and social service workers.⁷

Prevalence estimates. Prevalence estimates for elder abuse differ because studies have tended to use varying definitions, methodologies, and locales.^{1,8-10} Most research has been conducted in Western countries and among cognitively intact, community-dwelling elderly patients, with reported estimates ranging from 2.2% to 18.4%.¹¹⁻¹⁵ A study conducted in Canadian family practices, although not formally designed to measure prevalence, has suggested rates of senior mistreatment in the range of 12.0% to 13.3%.¹⁶

Risk factors. Research into elder abuse risk factors initially sought common factors for all aspects of abuse.¹⁷ For example, factors suggested to predispose care receivers to mistreatment include frailty, older age, female sex, dependency on the abuser, decline in mental health or cognitive impairment, impaired activities of daily living, problem behaviour, tendency to be physically or verbally abusive, isolation, and absence of anyone to call on for help. In contrast, factors suggested to predispose caregivers to mistreating someone include presence of caregiver stress, poor mental health, psychiatric illness, alcoholism, drugs, financial dependency on the care receiver, and being male. Research is now beginning to suggest that each manifestation of elder abuse might carry its own specific risk factors.

Elder abuse manifestations

Physical abuse: Physical abuse might include infliction of physical pain, injury, or willful deprivation by a caregiver or other provider of services necessary to maintain mental and physical health. Specific examples are summarized in **Box 1**.¹⁸⁻²⁰ Resultant signs and symptoms might include unexplained bruises (especially finger- or knuckle-shaped bruises, commonly on the face, neck, and trunk); welts (especially on palms and soles in a linear distribution); lacerations, abrasions, and scars; unexplained sprains, fractures, or multiple traumas; unexplained behaviour changes suggesting undermedication or overmedication; unexplained physical pain; bruising, inflammation, tenderness, abrasions, or trauma to the genital area, suggesting sexual abuse;

Box 1. Acts suggestive of physical abuse

The following are suggestive of physical abuse:

- Improper physical or chemical restraint
- Use of a weapon
- Individual hit, slapped, kicked, tied, shaken, choked, grabbed, pushed, shoved, slammed against a wall, punched, pinched, scratched, bit, burned, or scalded
- Twisted limbs
- Rough transfers
- Frequent, unexplained, or inconsistently explained falls and injuries
- Multiple visits to the emergency department
- Sexual abuse
 - Sexual contact, touching, rubbing, or masturbation that is forced, tricked, coerced, or manipulated, or when senior lacks capacity to consent
 - Verbal threats or forced (hitting, holding down, weapon use) to give or receive oral, genital, or anal sex
 - Individual forced to view or participate in pornographic or sexually explicit pictures or videos
 - Offensive sexual talk

Data from Aravanis,¹⁸ Lachs and Pillemer,¹⁹ and Dyer et al.²⁰

and apprehensiveness, withdrawal, anxiety, and sadness (which might include a spectrum of depressed mood, minor depressive symptoms, or major depression).

Psychological abuse: Psychological abuse might include willful or reckless verbal or nonverbal infliction of emotional or mental anguish and the use of physical or chemical restraint, medication, or isolation as punishment or as a substitute for treatment or care. Specific examples are summarized in **Box 2**.^{21,22} Resultant signs and symptoms might include apprehensiveness or physical avoidance; avoidance of eye contact or continual eye darting; unexplained quietness, passivity, withdrawal, and decreased social contact with people; anger, depression, or weight loss; a caregiver who tries to answer for the senior or to prevent a private interview or examination of the older adult; frequent requests for sedating medication; and frequently canceled appointments.

Financial or material abuse: Financial or material

Box 2. Acts suggestive of psychological abuse

The following are suggestive of psychological abuse:

- Lying to the individual
- Hiding belongings
- Humiliating or infantilizing
- Making demeaning jokes
- Coercion
- Inappropriate shouting or yelling
- Controlling contact with people (social isolation from family, friends, etc)
- Threatening to hit or throw something
- Talking disrespectfully
- Not respecting privacy
- Not respecting belongings or threatening to destroy property
- Insulting, swearing, name calling, or putting down
- Threatening with weapons, deprivation, punishment, guardianship, abandonment, or institutionalization
- Intentional overmedication

Data from Clarke and Pierson,²¹ and Bonnie and Wallace.²²

abuse might include expenditure, diminution, or use of property, assets, or resources of a person without the voluntary consent of that person or that person's legally authorized representative. Specific examples are summarized in **Box 3**.²³⁻²⁶ Resultant signs and symptoms might include unexplained anxiety, apprehensiveness, or avoidance; social withdrawal and decreased contact with people; depression and weight loss; being undermedicated; clothing that is inadequate or inappropriate for the weather; and tearfulness or guilty feelings about identifying the abuser.

Neglect: Neglect is the failure of a caregiver or mandated person to comprehensively attend to food, water, shelter, clothing, medication, safety, access to health care services or appointments, and protection

Box 3. Acts suggestive of financial or material abuse

The following are suggestive of financial or material abuse:

- Improper taking, misuse, or concealment of resources, property, or assets with or without coercion, enticement, intimidation, or deception
- Use of bank account, money, or credit or debit cards against the individual's will or without his or her knowledge
- Individual forced to give power of attorney
- Cashed cheques or property sold and money kept
- Forged signatures
- Individual forced to sign documents against will or understanding
- Misinformation about funds
- Misappropriation of funds, property, or power of attorney for personal gain
- Employment of service people for personal gain

Data from National Center on Elder Abuse,^{23,26} Tueth,²⁴ and Hafemeister.²⁵

from abuse or exploitation. Self-neglect (not unique to seniors) might be reflective of personal problems that generally fall outside the realm of elder abuse. Specific examples of neglect from third parties are summarized in **Box 4**.^{18,20,21} Resultant signs and symptoms might include poor mobility; decubitus ulcers, bedsores, and pressure sores; poor hygiene and body odour; frequent infections; unexplained or uncontrolled medical conditions; weight loss, fearfulness, anxiety, or depression.

Box 4. Acts suggestive of neglect

The following are suggestive of neglect:

- Denial of access to or assistance with necessary aids (eg, walkers, wheelchairs, eyeglasses, hearing aids)
- Individual left alone or unsupervised
- Unsanitary living conditions
- Home too hot or too cold
- Individual denied access to telephone
- Inappropriate clothing; diapers or bedding not changed
- Medications not or irregularly supervised
- Poor dietary intake; cachexia
- Delays in seeking treatment
- Inconsistent follow-up
- Frequent switching of physicians

Data from Aravanis,¹⁸ Dyer et al,²⁰ and Clarke and Pierson.²¹

Institutional neglect: Elder abuse is not limited to the home or to a community encounter, but might occur within retirement homes, assisted living facilities, nursing homes, and hospitals. Specific examples are summarized in **Box 5**.²⁷ Factors postulated to explain neglect of residents include poor working conditions, unpredictable work schedules, low salaries, inadequate staff training and supervision (especially to deal with disruptive or

insulting behaviour by the residents), low staff motivation, prejudiced attitudes to certain seniors, and noncongruence between a facility's mission and the particular health and environmental needs of an older adult.²⁸

Box 5. Acts suggestive of neglect in institutions

The following are suggestive of institutional neglect:

- Inadequate custodial care
- Inadequate supervision of institution residents
- Low or unpredictable nursing and nursing aide care
- Delays in response time to needs of seniors
- Inadequate nutrition
- Substandard, overcrowded, or unsanitary living environments
- Poor staff communication skills
- Language competencies not adequate to meet seniors' needs
- Inappropriate or aggressive staff-client interactions
- Misuse of physical or chemical restraints

Data from Hawes et al.²⁷

Case evolution.

You consider other ways to reach out to Mrs B. You wonder to what extent her resistance (self-neglect) reflects suspicion of the health care community because of the memory of her father's experience with institutional neglect, and how much is the outcome of denial about her deterioration. Parallel to this you also reflect on how much the apparent family neglect from the daughter is owing to the daughter's own denial versus some potential secondary gain. You contact the daughter again to inquire in a general way about what financial assets Mrs B. might have to support her care in the future. You learn that the daughter holds power of attorney, but infrequently checks into Mrs B.'s financial affairs. In fact, while Mrs B. employs a woman a few times a week to help with cleaning and meals, the daughter acknowledges she knows little about this person and what she is paid.

The multifaceted nature of this case prompts you to seek further information on elder abuse and how

to proceed, while keeping the identity of the patient anonymous. Within most communities this support is available from local police dedicated to mistreatment of seniors or from adult protection or social services. The social worker you contact observes that while Mrs B. appears to show some signs of poor judgment, she is nonetheless not legally impaired and cannot be forced to change things against her will. The social worker reminds you of the often subtle and frustrating presentation of elder abuse, and that a number of manifestations of abuse might coexist. For example, she notes that Mrs B.'s infrequent office visits might be a way of hiding manifestations of physical abuse. She therefore recommends periodically scheduled visits initiated by your office to help you and your nurse keep an eye on Mrs B. on a regular basis.

Detection of elder abuse. Elder abuse detection is challenging because of its sometimes vague or confusing signs and symptoms, and its complex social implications. Guidelines do not agree about whether physicians should screen for mistreatment of older adults²⁹; nonetheless, physicians might be confronted with situations that arouse suspicions of such abuse. The Elder Abuse Suspicion Index (EASI) (Table 1) might be a useful tool to employ in that context. Family physicians report that the EASI is simple to use and can be administered quickly, and that its use is a convenient means of learning about the scope of elder abuse.²⁹ It comprises questions that are validated for use in the office setting on seniors with Mini-Mental State Examination scores of 24 or higher, and its psychometric properties and their implications have been described.²⁹ It is available in several languages,³⁰ and in its English and French versions the wording has been found to be understandable and acceptable to seniors across a broad age spectrum.³¹ It can be used repeatedly to desensitize patients to questioning.²⁹ Its simplicity might help minimize negative feelings intrinsic to many victims, including denial; reluctance to report abuse because of not wanting to see the abuser punished; a sense of embarrassment, humiliation, or shame; or fear

Table 1. Elder Abuse Suspicion Index: Questions 1 through 5 are asked of the patient and question 6 is answered by the physician; 1 or more positive responses on questions 2 to 6 could suggest elder abuse.

QUESTIONS: OVER THE PAST 12 MONTHS ...	ANSWER (CIRCLE ONE)	
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	Yes	No
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No
6. Doctor: Elder abuse might be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the past 12 months?	Yes	No

of breaking family solidarity, of abuser retaliation, or of loss of abuser help with care.³²

Mandatory elder abuse reporting laws for detected cases exist in only a few Canadian jurisdictions, and currently there is no case law in Canada addressing physicians' failure to report suspected cases. The EASI was designed not necessarily as a definitive diagnostic tool but rather to generate reasonable suspicion to justify a physician doing a more in-depth exploration. This might include a culturally sensitive inquiry with a possible victim in the absence of others, an abuse-oriented physical examination, or obtaining patient permission to make referral to an appropriate community expert in elder abuse. To facilitate this process a pocket card has been created that reproduces the EASI questions and provides unique Canadian provincial and territorial resources that doctors can use to get assistance or advice once there is a concern or suspected case of abuse. This EASI pocket card is available online,³³ or durable hard copies can be purchased.³⁴

Conclusion

Elder abuse is an important cause of morbidity and mortality in older adults for which family physicians need to be vigilant. Family physicians are, by virtue of their frequent contact with seniors (and optimally a strong trusting relationship established with them over time), well placed to try to identify and comprehensively document signs and symptoms suggestive of mistreatment. The EASI is an internationally recognized tool validated for use by family physicians to help in this process. Once there is a suspicion of abuse, physicians are encouraged to consult with adult protection or social services or with police officers trained in assessment of and response to mistreatment of older adults. 🌿

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Competing interests

None declared

Contributors

Dr Yaffe completed the literature search. Both authors reviewed the literature and prepared the article for publication.

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