

Prevention and Early Identification of Elder Abuse

Jason Burnett, PhD^{a,b,*}, W. Andrew Achenbaum, PhD^{a,b,c},
Kathleen Pace Murphy, PhD^{a,b}

KEYWORDS

• Elder abuse • Screening • Ageism • Adult protective services • Mistreatment

KEY POINTS

- Early identification and prevention of elder abuse requires challenging ageist perceptions.
- Increasing public awareness and health professional training is needed to differentiate abuse in older adults from “normal” aging.
- More research is needed to identify characteristics that increase the risk of elder abuse and subsequent studies to inform best practices for reducing harmful outcomes.
- Concise assessments can be used effectively during brief clinical visits with older adults to identify risk factors and indicators of abuse.

INTRODUCTION

The United States is undergoing an aging boom. Every day, 8000 Baby Boomers reach the retirement age of 65. Currently, adults 65 years and older represent 14% of the US population; by 2050, this number is expected to reach 25%.¹ This upsurge in societal aging will most likely be accompanied by a sharp increase in callous acts of abuse for many older adults, causing horrific suffering regardless of social class, gender, or ethnic and cultural background. Elder abuse escalates the burden on limited public health resources.² We need both effective prevention strategies to protect an aging population at risk for elder abuse as well as early detection of warning signs and symptoms.

^a Division of Geriatric and Palliative Medicine, Department of Internal Medicine, Harris Health System, Texas Elder Abuse and Mistreatment Institute (TEAM), UT Health, 3601 North MacGregor Way, Houston, TX 77004, USA; ^b Consortium on Aging, Texas Elder Abuse and Mistreatment Institute (TEAM), UT Health, 3601 North MacGregor Way, Houston, TX 77004, USA; ^c Graduate School of Social Work, The University of Houston, 110 HA Social Work Building, Houston, TX 77204, USA

* Corresponding author. Division of Geriatric and Palliative Care, Department of Internal Medicine, UT Health, 3601 North MacGregor Way, Houston, TX 77004.

E-mail address: Jason.Burnett@uth.tmc.edu

DEFINITION

Over the past 30 years, elder abuse has received greater and greater attention from health and social service professions and law enforcement agencies. The US Centers for Disease Control and Prevention,³ the US Administration on Aging (now known as the US Administration on Community-Living),⁴ and the World Health Organization have made it a priority.⁵ Although there is no universally accepted definition of elder abuse, existing ones are consonant with the (1985) Elder Abuse Prevention, Identification and Treatment Act, which defines abuse as “the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness.”⁶ The World Health Organization further describes elder abuse as an act of violence and a human rights violation.⁷ Given the latitude of interpretations under this definition, it is not surprising that public officials and inter-professional researchers broaden their understanding of the scope of elder abuse. Identifying and addressing the causes and consequences of elder abuse, broadly understood, speaks to many comorbidities and environmental hazards associated with late-life vulnerabilities.

TYPES OF ELDER ABUSE

The US National Center on Elder Abuse identifies 7 unique types of elder abuse and provides definitions for each: Physical abuse, sexual abuse, financial exploitation, caregiver neglect, psychological and emotional abuse, abandonment, and self-neglect.⁸ **Table 1** lists definitions for each type of abuse along with their most recent US population-based prevalence estimates.^{8,9} These estimates represent self-reported abuse by cognitively intact community-dwelling older adults.

Type	Definition	Prevalence (%)
Physical abuse	Bodily injury, physical pain or impairment owing to use of physical force	1.6
Sexual abuse	Any kind of non-consensual sexual contact	0.6
Psychological/emotional abuse	Verbal or non-verbal acts that cause emotional and/or psychological anguish, pain, or distress	3.2
Financial exploitation	Improper or illegal use of an older adult's money, property or assets	5.2
Caregiver neglect ^a	Failure or refusal to fulfill one's caregiver obligation or duties to an older adult	5.1
Self-neglect ^a	Older adult self-behaviors that threatens the individual's own health and safety	5.1
Abandonment	Desertion of an older adult by a person who assumed responsibility for their care	—

Note: The incidence estimates represent the findings of the most recent US population-based study of elder abuse in cognitively intact community-dwelling older adults. These rates are estimated to be higher among the cognitively impaired.

^a Self-Neglect and caregiver neglect were combined in this study for a prevalence of 5.1%.

INCIDENCE AND PREVALENCE

That the full extent of elder abuse, both in the US and worldwide, remains unclear reflects difficulties in detecting the problem; there are variations in mandatory reporting standards and substantiation criteria, as well as in the methods used to obtain prevalence estimates.^{10,11} The elder abuse literature suggests approximately 80% of true elder abuse cases are not reported to authorities.¹² For these reasons, estimates probably are greatly underestimated. Several US population-based studies provide annual elder abuse incidence estimates ranging from 1% to 10%.^{13,14} The most recent US population-based prevalence study found that 11% of cognitively intact community-dwelling older adults 65 years of age and older experienced at least 1 form of abuse in the 12 months before the study. As shown in **Table 1**, financial exploitation was the most commonly reported type of abuse, closely followed by neglect.⁹ Given that overall estimates of older adults constitute 14% of the US population, anywhere from at least 400,000 to 4,000,000 older adults are currently mistreated. Worldwide, the World Health Organization estimates that anywhere from 1% to 35% of older adults have been victimized or will experience elder abuse.¹⁵ With a rapidly aging population around the globe, the problem of elder abuse will grow exponentially worse in the coming years unless preventive measures are set in place.

MORBIDITY AND MORTALITY

The elderly are the most heterogeneous segment of the population. Many older adults are healthy. Many older adults suffer from multiple chronic health conditions, including those who have lower physiologic and psychological reserves limiting their ability to cope with stressful situations. They experience 2- to 3-fold increases in all-cause mortality compared with older adults that are not abused.^{16,17} Alarmingly, what emerges from the data is that elder abuse significantly predicts mortality in older adults independent of a broad range of other social, functional, physical, medical, mental health, and demographic qualities. Elder abuse is such an adverse and burdensome event that mistreated older adults with little or no disease symptomatology seem to be at risk for early mortality.

RISK FACTORS

Every older person is at risk. Elder abuse occurs across many different socioeconomic statuses and cultures. There are certain characteristics that place older adults at greater risk for being victimized. Although older persons who lend money to children owing to a hardship may not be at high risk for abuse, evidence suggests that the risk increases significantly, although not ubiquitously, if co-residency or substance abuse are preconditions. Because elder abuse is enmeshed with many factors, we must explore characteristics of both the victim and the perpetrator that increase the likelihood of abuse. So, although the risk factors are fairly well established, there is a compelling need for evidence-based studies that determine whether certain social, environmental, and individual risk factor combinations pose differential risks of subsequent victimization. **Table 2** provides a list of common victim and perpetrator risk factors.¹⁸⁻²⁰

EARLY IDENTIFICATION AND PREVENTION: STATE OF THE LITERATURE

Much more research needs to be completed in the field of elder abuse to improve effective prevention and early identification. Despite substantial work to date, this is a relatively new field; we need better prevention and early identification strategies.

Victim/Perpetrator	Characteristics
Victim	Female, advanced age, cognitive impairment, co-habitation with others (especially family members), social isolation and poor social support networks, mental health problems, substance abuse, dependency on perpetrator for care, frailty
Perpetrator	Cognitive impairment, family history of abusive behavior, male, mental illness or mentally challenged, ≥ 40 y of age, financial or substance abuse dependency, adult child

This requires (1) addressing ageism, (2) expanding knowledge about subjective and objective abuse indicators, (3) increasing elder abuse screening in clinical settings, and (4) establishing elder abuse detection and prevention as routine medical care.

Ageism

In 1969, a pioneer in the field of aging, Dr Robert Butler coined the term “ageism” to capture discrimination against older adults simply based on their age and the aging process.²¹ Ageist assumptions can lead to inattention toward older adult health problems or equating aging with poor health. The blindness that results shadows health care professionals, patients, and society as a whole. Researchers have linked negative views of aging to functional decline, depression, isolation, despair, and disability, thereby increasing the risk for abuse and early mortality.²² Ageism has unexpected consequences; it impedes progress toward enhancing the prevention and early identification of elder abuse.

Ascribing serious medical problems to the vicissitudes of “normal” aging may divert true attention from the circumstances surrounding a health problem. For instance, decubitus ulcers, which have been linked to elder abuse, could result from severe end-stage diseases affecting mobility and malnutrition, but they may also indicate caregiver neglect.²³ Similarly, depression is a common mental health problem among abused elders.²⁴ Abuse may either lead to depression or contribute to a patient’s vulnerability. If health problems such as ulcers and depression are categorized as natural consequences of aging, rather than signs suggestive of abuse, vulnerable older adults may be left to endure and suffer ongoing abuse, a condition often occurring for years before it is detected.²⁵

Disparities in preventive care and medical treatment disparities also exist owing to age. Older adults are less likely than younger individuals to receive preventive care and, thus, may experience an increased likelihood of becoming dependent.²² Conversely, older people can positively or adversely contribute to their overall well-being by the relative degree to which they eat and drink in moderation, exercise regularly, and monitor their sleeping habits. The same goes for aggressive medical treatments, which providers may not deem appropriate for adults advancing in years. Foregoing treatment typically accorded people in their prime may reduce an elder’s ability to perform activities of daily living and engage in social activities, thus increasing isolation or dependency and subsequent abuse. For instance, a frail elder patient may be offered a wheelchair rather than physical therapy, further diminishing her musculoskeletal system and accelerating functional decline in several activities of daily living, which increases the likelihood of dependence.

There is a national shortage of geriatric trained medical professionals. Even now, only 10% of US medical schools require students to participate in geriatric coursework or

rotations.²² Because many health care professionals may not be able to detect the signs of elder abuse, much less how to screen for it, we must enhance training in geriatric medicine nationwide if we are going to improve prevention and early detection of elder abuse.

Increasing Awareness and Elder Abuse Indicators

Detecting elder abuse is rarely an easy task, even for individuals trained to identify it.²⁶ Aspects of abuse complicate detection. Roughly 95% of older adults live in their homes, the site of the abuse. By the time the targeted older adult is seen by a physician, family member, or a neighbor, the elder's injuries or psychological abuse may have dissipated to a subclinical level undetected by a brief physical examination or clinical visit. Likewise, in many cases the signs of abuse are subtle, masked by the aging process.²⁷ As noted, not knowing what overt and subtle signs to look for diminishes early identification. However, there are indicators and markers of elder abuse. Using them in a thorough patient assessment is important for an accurate diagnosis. The older adult patient should be examined alone and away from the caregiver. A complete physical examination in a patient gown is warranted in suspected abuse. Physicians should pay particular attention to areas often hidden by clothing, socks, and shoes. This approach allows the physician to ask direct and nonthreatening questions to ascertain the history behind the clinical picture. **Table 3** provides a list of indicators for the different types of abuse.²⁸

Abuse Type	Indicators
Physical abuse	Fractures, welts, lacerations, bite marks, burns, bruises, untreated injuries, internal injuries, repeated history of falls, repeated emergency department visits, traumatic alopecia
Sexual abuse	Difficulty walking or sitting, pain or itching in the genital area, unexplained sexually transmitted diseases, vaginal or anal bleeding, torn, stained or bloody underclothing, bruising around genital or breast regions
Psychological/emotional abuse	Emotional upset, agitation, depression, suicidal ideation, hyper vigilance toward abuser, withdrawn, unusual behavior such as sucking, biting, rocking, crying, self-mutilation
Financial exploitation	Sudden changes in bank accounts, inability to afford medications, unexplained disappearance of possessions, unexplained asset transfer(s), unexplained loss of pension or social security checks
Caregiver neglect	Dehydration, malnutrition, decubitus ulcers, unexplained deterioration in health, failure to thrive, lack of routine medical care or medications, urine burns, multiple hospital and emergency department admissions, repeated falls, poor hygiene, unexplained weight loss
Abandonment	Cognitively-impaired older adult left in emergency department, victim place on public transportation with a 1-way ticket, older adult is left alone unsafely for periods of time
Self-neglect	Unkempt appearance, withdrawn, depressed, isolated, hazardous or unsafe living conditions, unexpected to unexplained deterioration in health, untreated health conditions, weight loss, dehydration, poor hygiene

Adapted from Brandl B, Dyer CB, Heisler CJ, et al. Elder abuse detection and intervention—a collaborative approach. Springer Series on Ethics, Law and Aging. New York: Springer Publishing Company; 2007. p. 79–100.

Bruising and Fall-Related Injuries

Physical indicators provide evidence used to determine whether an elder's injury occurred as a result of an accident or an intentional act of abuse. In 2007, unintentional injury in adults 65 years of age and older was the ninth leading cause of death. In 2009, falls were both the most common type of unintentional injury in older adults as well as the seventh leading cause of violence-related injury in older adults.²⁹ Research focused on types of injury to distinguish accidental causes from trauma is helpful.

In 2005, Mosqueda and colleagues³⁰ studied the association between bruising and physical abuse in older adults. The placement of bruises, the study found, differentiate accidental bruising from nonaccidental bruising. In fact, an estimated 90% of accidental bruises presented on the extremities of the older adults, not on the head or neck region, buttocks, genitalia, or soles of the feet. This study also examined the color and duration of bruising only to find that these indicators were not reliable evidence regarding the intentionality of the injuries.

In 2009, Wiglesworth and colleagues³¹ extended the earlier bruising study to examine location and size of bruising associated with physical abuse. This project relied on 67 older adults reported to Adult Protective Services (APS) for physical abuse. After an expert panel reviewed the case history and determined, by consensus, whether physical abuse occurred, the investigators compared bruise size and location between the groups. Their findings that bruises associated with elder abuse are commonly large (>5 cm), and are present on the face, lateral right arm, and posterior torso, support the Mosqueda (2005) study.³⁰

There is evidence that traumatic injuries of patients presenting to health care providers may be missed. For example, approximately 23% of emergency department visits occur in older adults with injuries.²⁹ In 2011, Friedman and co-workers³² investigated the injuries of traumatic elder abuse victims treated in an emergency department. This study found that wounds in the forms of fractures, internal injuries, and open and penetrating wounds were more common in elder abuse victims than unabused older adults.

In 2012, Ziminski and colleagues²⁹ conducted a 2-year retrospective study of emergency department visits by older adults. They assessed the relation between emergency department visits and injuries in cognitively challenged older adults. Cognitive impairment was not significantly related to falls, but the data indicate that individuals with cognitive impairment suffered more injuries in the head, neck, and face region; lower limb; upper limb; and trunk. In contrast, those whose injuries were not related to falls were far more likely to suffer open wounds. These open wounds could be the result of trauma related to physical abuse by caregivers or self-neglect. A recent case-control study by Burnett and colleagues (2013),²³ investigating the forensic markers of elder abuse in older decedents found that a history of decubitus ulcers were predictive of prior elder abuse substantiation by APS.

Burns and Lacerations

Burns and lacerations are common injuries seen in health care settings. Burns often are indicative of abuse in older adults. Studies estimate that approximately 40% to 70% of burns in older adults are linked to elder abuse.³³ Clinical and forensic investigations of burn patterns in older adults resemble those found in child abuse³⁴ and, thus, should increase suspicion of abuse rather than assuming these injuries occurred by accident.

Lacerations are equally difficult to attribute to elder abuse because skin integrity is reduced as part of aging. Lacerations are more likely to occur in older adults as a result

of blunt force trauma, restraints, and friction, but leave less evidence regarding the type of abuse. Nonetheless, abrasions retain the form of the device used to create the trauma.²⁷

SCREENING AND MONITORING FOR ELDER ABUSE RISK FACTORS

Systematic screening for risk factors and indicators of abuse are critical for early detection and prevention. Multiple studies show that declines in physical and mental health as well as limited social networks, cohabitation, and isolation lead to higher risks for increased dependency and subsequent elder abuse.^{18,19,28} Unfortunately, very little systematic screening of elder abuse and its risk factors occurs in clinic settings.³⁵ Physicians are in a position to oversee screening and prevention of elder abuse. They often see their elderly patients 5 or more times per year.³⁶ Thus, physicians develop trusting relationships with the patients and have multiple opportunities to observe and discuss changes in cognition, function, mental health, social, living, and financial statuses.

Comprehensive Geriatric Assessments

Comprehensive geriatric assessments (CGA) are the gold standard for assessing the health and well-being of older adults. CGAs often incorporate the physical health, mental health, and social and cognitive domains important for quality of life and protection from elder abuse.³⁵ Although this approach has been shown to be helpful in identifying problem areas, CGAs are cumbersome and time consuming, and may require additional training, making them impractical for brief clinical visits with older adults. Therefore, family physician practices, nongeriatric specialists, and emergency departments are not likely to perform CGAs, suggesting the need for alternative approaches.

Referrals for Comprehensive Geriatric Assessments

Geriatric medical teams are trained in CGA and accustomed to completing some combination of these assessments on a routine basis. Such teams can be a resource for non-geriatrics-trained health care professionals. Referrals to geriatric medicine teams for an annual CGA would afford a baseline evaluation of the different risk factors for elder abuse. Alternatively, the primary care provider might choose to perform a CGA to monitor changes over the year that may warrant further investigation into the possibility of elder abuse. For emergency department personnel, consultations with geriatric medicine teams might facilitate determining the presence of abuse or whether older adults upon discharge are at risk for abuse.

Periodic Assessment of Elder Abuse Risk Factors

Clearly not every clinical visit can include a lengthy battery of elder abuse risk factor measures. Nonetheless, it would be beneficial to assess executive functioning, memory, depression, and activities of daily living at routine intervals. Several standardized tests, which are relatively quick and efficient for these subtle domains, could be performed once or twice a year and supported by vigilant monitoring of changes in status in subsequent visits. Depression may undergo more rapid development, but these other domains are not likely to change significantly in short periods of time. Should changes be noticed, further investigation should ensue to rule out elder abuse as a potential contributing cause for the change in health status. Likewise, health care professionals should be skeptical of repeated “accidental injuries” in older adults; a significant portion of these injuries may be related to abuse.

Social history and qualitative interviews

An older adult may choose not to reveal being abused out of shame, fear of further abuse, protection of a loved one, or simply because they are unable to communicate these incidents owing to cognitive impairment.¹⁹ This does not mean that questions regarding elder abuse should not be routinely asked. Patients and caregivers should be questioned separately. Health care providers should at the very least ask open-ended questions regarding the older adult's social engagement, financial decision making, and fear of being unsafe or injured. Questions even as neutral as "Is there anything going on at home that you would like to talk about?" might reveal information indicative of potential elder abuse. This may lead to a confession of being injured or to other vague complaints that may be coded communication regarding ongoing abuse. Other questions to consider include: "Has anyone touched you without your permission?"; "Has anyone hurt, hit or treated you roughly?"; "Has anyone taken your personal possessions such as your money, car, or valuables without your permission?"; "Has anyone yelled or sworn at you?"; and "Has anyone made fun of you or hurt your feelings?"

The verbal information gained from these exchanges may be diminished when victims of abuse exhibit behaviors such as withdrawal, anxiety, missed appointments, depression, stress, or trauma. In these cases, it may be helpful to assess the cause of these behaviors to rule out the suspicion of elder abuse. In addition, if the caregiver insists on answering for the patient, downplays the patient's complaints, acts overly compassionate, refuses to allow the interview with the patient to take place without the caregiver present, or cancels the patient's appointments, the clinicians' suspicion for abuse should be elevated.

ELDER ABUSE CLINICAL ASSESSMENTS

The American Medical Association recommends that all geriatric patients receive elder abuse screening.³⁷ In cases where injuries are not extensive or do not require emergency care, an older adult may not present to a physician until after the salient indicators are gone. Thus, relying on physical signs may not be informative. Since 1975, when Burston first reported on "granny battering" in the *British Medical Journal*, there have been considerable efforts to develop elder abuse assessments despite the lack of available criteria.³⁸ Because the burden of identification is falling on the shoulders of health care professionals, most of the assessments were designed to identify suspicion of elder abuse during brief clinical visits, such as emergency departments and outpatient settings.

Some of the measures such as the CGAs and conflict tactics scale³⁹ provide an indirect assessment of elder abuse. Other measures such as the Elder Abuse Assessment Instrument,⁴⁰ Brief Abuse Screen for the Elderly,³⁵ Indicators of Abuse,⁴¹ Hwalek-Sengstock Elder Abuse Screening Test,⁴² Elder Abuse Suspicion Index,⁴³ American Medical Association Screening of Abuse,¹⁹ the Vulnerability to Abuse Screening Survey,⁴⁴ and the Geriatric Mistreatment Scale⁴⁵ were specifically designed to detect possible elder abuse. These assessments vary in length, elder abuse types assessed, and psychometric appraisal. Although most elder abuse assessments have internal reliability testing, many have not undergone more rigorous construct validation or measurement invariance testing to determine whether these assessments are equally useful across different genders and ethnic/cultural contexts. Despite these limitations, these assessments can still be used to screen older adults to provide potential early identification and prevention. After all, a positive screen does not ubiquitously mean that elder abuse is occurring, but rather that further information should be gathered. **Table 4** provides a list of elder abuse assessments that may be suitable for clinical settings.

Table 4
Elder abuse assessments and clinical suitability

Assessment	Items	Administration	Psychometrics	Clinical Suitability
Elder Assessment Instrument (EAI)	42	Completed by a professional to assess physical, social, medical, independence in older adults. Also provides a summary	Content and construct validity; good inter-rater agreement; sensitivity = 0.71 specificity = 0.93; item-reliability = 0.84; test-retest = 0.83	Good psychometrics, but lengthy
Brief Abuse Screen for the Elderly (BASE)	5	Training required to assess physical, psychological, financial mistreatment and neglect; takes 1 min to complete	Face validity and inter-rater agreement	Brief, but requires specialized training
Hwalek-Sengstock Elder Abuse Screening Test (HS-EAST)	6	Self-report or interview by a professional	Construct and predictive validity, weak item reliability, but good cross-cultural adaptation	Brief, but primarily assesses domestic violence
Elder Abuse Suspicion Index (EASI)	6	Completed by health care professional to assess risk, neglect, verbal, psychological, emotional, financial, physical and sexual abuse over a 12-mo period; 2 min to complete	Sensitivity = 0.77; specificity = 0.44	Brief with adequate ability to detect true cases of abuse, but may result in higher numbers of false positive findings of abuse
American Medical Association Abuse Screen (AMAAS)	9	Brief assessment by health care professional to assess for social isolation, financial exploitation, sexual abuse, caregiver neglect, and emotional/verbal abuse	None reported	Brief, but no psychometric performance assessment
Vulnerability to Abuse Screening Scale (VASS)	12	Self-report of dependency, dejection, coercion, and vulnerability	Moderate ranges of reliability and moderate to good construct validity	Brief, but not unreliable in assessing coercion by others
Geriatric Mistreatment Scale (GMS)	22	Assesses physical, psychological and sexual abuse, caregiver neglect and financial exploitation	Internal reliability ranging from 0.55 (financial abuse) to 0.87 (sexual abuse)	Good psychometrics, but lengthy and need for training

Elder Assessment Instrument

The Elder Assessment Instrument is a 41-item instrument containing 7 sections. The instrument's first 5 sections assess clinical manifestations and subjective patient responses related to general assessment and, more specifically, elder abuse, neglect, exploitation, and abandonment indicators. The Elder Assessment Instrument uses a Likert scale, resulting in a quantitative value for each elder abuse domain. The sixth section is a summary section where the assessor provides an overall likelihood of the presence of elder abuse for the individual patient. The last section invites comment and prompts development of a follow-up plan. This tool has been shown to have acceptable construct validity, interrater agreement, and good sensitivity and specificity. Unfortunately, its length diminishes its appropriateness in busy clinical settings.⁴⁰

Brief Abuse Screen for the Elderly

The Brief Abuse Screen for the Elderly contains only 5 items. It has good interrater agreement, but no other psychometric evaluations have been conducted. Despite only taking 1 minute to complete, deploying the Brief Abuse Screen for the Elderly requires training. The Brief Abuse Screen for the Elderly discriminates between abusive and nonabusive caregivers, but it does not include a question on self-neglect.⁴¹

Hwalek-Sengestock Elder Abuse Screening Test

The Hwalek-Sengestock Elder Abuse Screening Test (HS-EAST)⁴² has been reduced to a 6-item risk assessment of domestic violence in older adults and vulnerability to physical harm. This scale could certainly serve clinicians as a brief elder abuse screening tool. Recent psychometric evaluation has shown that the HS-EAST can be cross-culturally adapted to assess for elder abuse and vulnerability in Portuguese populations.

Elder Abuse Suspicion Index

The Elder Abuse Suspicion Index is a 6-item assessment designed to identify older adults who may be being abused. It takes approximately 2 minutes to administer. The Elder Abuse Suspicion Index was validated in family practices and ambulatory care settings. Its sensitivity and specificity are recorded as 0.47 and 0.75, respectively. These values suggest that, although the Elder Abuse Suspicion Index may not always identify abuse when it is occurring, it performs fairly well at identifying those that have not been abused. An additional strength is that it was validated against a detailed elder abuse Social Work Evaluation. The first 5 questions are asked directly to the patient. These questions cover basic and instrumental activities of daily living dependency, neglect, emotional abuse, financial exploitation, and sexual abuse. The last question directs the treating physician(s) to assess for various patient behaviors and characteristics uncommon for the older adult and associated with elder abuse. These cues include withdrawn nature, poor eye contact, malnutrition, medication noncompliance, cuts, bruises, poor hygiene, and inappropriate clothing. Yes to any of these questions indicates potential abuse.⁴³

American Medical Association Abuse Screen

The American Medical Association Abuse Screen is a brief assessment with only 9 questions. The questions listed in this assessment evaluate the domains of social isolation, financial exploitation, sexual abuse, caregiver neglect, and emotional and psychological abuse. Although very brief, the questions in this assessment could be quite informative. Questions include: "Are you alone a lot?", "Are you afraid of anyone

at home?”, and “Has anyone ever touched you without your consent?” Affirmative answers should, at the very least, raise suspicion and prompt further discussion.¹⁹

Vulnerability to Abuse Screening Scale

The Vulnerability to Abuse Screening Scale is a 12-item scale with 4 domains that cover vulnerability, dependence, dejection, and coercion. This scale is specifically designed to assess for elder abuse, and combines 10 questions from the original HS-EAST screening test with 2 additional items, including threatening behavior from others and whether or not the older adult is afraid of anyone in their family. Its vulnerability and coercion scales demonstrate moderate to good construct validity. Overall, the reliability of the different domains on the Vulnerability to Abuse Screening Scale ranges from 0.31 (coercion) to 0.74 (dependency), which are indicated to be adequate for brief screening.⁴⁴

Geriatric Mistreatment Scale

The Geriatric Mistreatment Scale is a 22-item assessment designed to assess 5 domains of elder abuse. Each question refers to the 12 months before the interview. The domains include physical and psychological abuse, caregiver neglect, financial exploitation, and sexual abuse. The Geriatric Mistreatment Scale also asks who is responsible for the abuse. The overall internal reliability of the scale is reported to be good with a Cronbach's alpha of 0.83. The reliabilities for the domains were psychological abuse (0.82), physical abuse (0.72), financial abuse (0.55), caregiver neglect (0.80), and sexual abuse (0.87). All domains except for financial abuse have adequate to good item reliabilities, indicating the ability for the items to all measure their targeted type of abuse.⁴⁵

In-Home Assessments

Like most behaviors punishable by law, attempts are often made to conceal elder abuse and occurrences often happen in privacy. In fact, acts of elder abuse occur mostly in the privacy of the older adult's home.²⁸ As mentioned, perpetrators and victims often try to hide these abuses from physicians, neighbors, and social services. Therefore, treating older adults in clinical settings provides only a partial picture of the dynamic sociocultural context wherein most elder abuse occurs. To gain a more complete picture of potential abuse, it may be important to complete an in-home assessment and determine if proper care of the older adult is being provided. Because home visits are time intensive, it may be prudent to perform home visits for patients when suspicion for potential abuse is high. Also, this may be the only effective way to detect self-neglect in older adults.

FEASIBILITY OF CLINICAL SCREENING

Within the United States, the Joint Commissions that accredits hospitals requires emergency departments to screen every patient for potential abuse or neglect regardless of age. Bond and Butler¹⁹ (2013) recommend use of the EASI or the American Medical Association Abuse Screen to identify elder abuse in emergency departments.

A recent study by Russell and colleagues⁴⁶ (2012) reported on the feasibility of elder abuse screening in dental clinics. Older adult patients were approached in the waiting rooms and asked to answer sensitive questions for the HS-EAST regarding elder abuse. One third of the older adult patients refused to participate. Of those who participated, an alarming 28% scored high enough to indicate a high likelihood of current elder abuse. This feasibility study is especially important because it demonstrates that older adults, while waiting to be seen by a health care provider, are willing to undergo elder abuse screening. It is worth noting that the screening does not have to be

completed by the physician in most cases. When using the EASI, however, the physician or treating clinician must provide an answer to the last question regarding changes in the patients status over time.

REPORTING AND RESPONDING TO ELDER ABUSE

In 1975, the US federal government mandated states to establish social service agencies across the country.⁴⁷ In 2004, the federal government spent approximately one half of a billion dollars on state APS agencies across the country.⁴⁸ These monies were used by APS to investigate, substantiate, and provide services to adults with disabilities and older adults. Currently, 44 states have mandatory reporting laws for its citizens. Even in these states, many cases are unreported for multiple reasons including ageism, lack of public awareness regarding the identification of elder abuse, and lack of knowledge about where to report cases.

In 2004, Kennedy and colleagues⁴⁹ surveyed 250 family physicians and 250 general internists to assess the perceived magnitude of elder abuse and to determine their sense of responsibility for detecting, reporting, and intervening. Unanimously, physicians agreed that identifying and treating elder abuse is important. The vast majority (75%) reported that physicians could intervene effectively in elder abuse cases and 78% believed that primary care physicians were in the best position to detect elder abuse. These statistics are surprising; physician-initiated elder abuse reports to social service agencies account for less than 2% of the reported cases.⁵⁰

The same study provided evidence that 63% of the physicians polled never asked about elder abuse and only 31% reported encountering elder abuse in the 12 months before the survey. For those physicians who did encounter elder abuse, an alarming 94% stated that they were unable to prove elder abuse had occurred or decided not to report their cases to APS. Equally discouraging is the finding that 98% of those surveyed reported the perception of being inadequately trained to effectively detect, treat, and manage elder abuse cases.⁴⁹

In 2010, a separate study by Almogue and colleagues⁵¹ echoed these findings by showing that medical and nursing staff had low levels of knowledge regarding elder abuse issues and that they were unaware of laws and protocols for detection and reporting. Almogue and colleagues also reported that physicians wanted to be absolutely certain that abuse was occurring before reporting their patients to social services. Likewise, 75% of home health care providers stated that they would need conclusive evidence, such as eye witness to abuse, before proceeding.

Although some cases of elder abuse are obvious, many may be subtle and require further investigation for supportive evidence. Accordingly, it is important for health care providers to report potential elder abuse cases to APS even when definitive evidence is not available. A high suspicion of abuse by a health care professional warrants further investigation. In clinical settings, elder abuse should be treated like any other disease state. If there are symptoms, then further steps should be taken to confirm the diagnosis. Capezuti and colleagues⁵² (2011) provide a 3-pronged approach for health care providers to follow to improve the early identification and prevention of elder abuse:

- Recognition of real or potential abuse;
- Referral to proper source(s) for intervention; and
- Ongoing follow-up and evaluation.

These steps indicate both the need to screen for elder abuse and seek conclusive evidence, as well as the necessity to report potential cases of abuse to the proper authorities and investigative agencies. This approach presupposes continual ongoing

care and management of the older adults to improve early detection and prevent recurrent cases of elder abuse in the future.

A CLINICIAN'S POCKET GUIDE TO EARLY DETECTION AND PREVENTION OF ELDER ABUSE

As mentioned, physicians and health care providers woefully underreport elder abuse. **Fig. 1** presents a familiar reporting structure to help with the early identification of and

Subjective

The following statements may be a red flag indicating further investigation:

Abandonment: I am all alone. I have no one who cares for me.

Physical Abuse: They hurt me. Please don't tell anyone about the injury. Stories that do not correlate to the type of injury and/or physical signs and symptoms.

Exploitation: I don't know what happened to my money. I can no longer afford ...I have misplaced my jewelry or my money. I don't understand what happened.

Neglect: My caregiver is so busy, it is not their fault that they don't have time to feed me, get my medications, or change my diaper.

Psychological

Abuse: I don't want to complain, my son/daughter yell if I complain. Please don't make fun of me.

Self-Neglect: I'm fine, I don't feel like taking my medications or taking care of myself. I'd don't need to bathe much, I'm clean enough as I am.



Objective

Physical Manifestation
- Bruising in various stages of healing
- Contractures
- Falls
- Dehydration
- Fractures in various stages of healing
- Lacerations
- Diarrhea
- Fecal Impaction
- Malnutrition
- Inappropriate use of medications
- Poor hygiene
- Sexual abuse signs
- Pressure ulcers
- Urine burns
- Delirium

*CG=caregiver

Psychological Manifestation
Assess for Caregiver and Patient
- Anxiety
- Anxiety toward CG*
- Anger by patient toward CG*
- Depression
- Fearfulness
- Impatience toward CG
- Irritability toward CG
- Nervousness
- Nervousness toward CG
- CG impatience toward patient
- CG irritability toward patient

Sociological/Environmental Manifestation
- Recent Inability to pay bills
- Left alone in Emergency Room
- Nonadherence to medication
- Repeated ER admissions
- Repeated hospital admissions

See Table II for Additional Risk Factors



Assessment

Patient in immediate danger from abuse or neglect



• Refer to emergency services and Adult Protective Services (APS)

Unexplained or inconsistent explanations for physical findings, suspicious for mistreatment



• Refer to APS and emergency services if recent sexual abuse to gather forensic evidence

Diminished decision-making ability (risk of self-neglect)



• Utilize health care proxy, durable power of attorney if available
• Refer to APS if no family or friend available
• Contact primary care provider or referral to evaluate cognitive impairment

Not suspicious of elder abuse or neglect



• Complete routine medical exam
• Refer to other health care providers if needed

Plan

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Fig. 1. Subjective, objective, assessment, and plan (SOAP) process for identifying, reporting and preventing elder abuse. (Adapted from Chang AL, Wong JW, Endo JO, et al. Geriatric dermatology part II. Risk factors and cutaneous signs of elder mistreatment for the dermatologist. *J Am Acad Dermatol* 2013;68(4):533.e1-10; with permission.)

response to patients who may be experiencing the various types of elder abuse. The SOAP note has been taught in medical schools throughout the country for years. SOAP is an acronym for Subjective, Objective, Assessment, and Plan. Subjective data are the statements made by the patient or the caregiver. Subjective data include the reason for the visit (patient's chief complaint) and other pertinent historical information, such as the history of the present illness, review of body systems, medical and surgical history, and family and social history, medical review and the patient's allergies. Objective data are the signs the health care provider observes throughout the physical examination. These observations include the interactions between the older adult and the caregiver. Assessment is the health care provider's critical thinking, which formulates the differential diagnoses. The plan consists of interventions prescribed to address the patient's chief concern and the diagnoses identified.

In elder abuse, vague statements may often be a call for help. Further investigation of these comments may open the door for the elder person to expound on their particular situation. It is important to interview the older adult alone and away from the caregiver to allow the patient to speak freely and openly. They may directly state they have been hit and plead with you not to mention this anyone. It is also common for older adults to defend the caregiver's behaviors by reasoning that the caregiver was busy or overly stressed in response to caring for the older adult. For these reasons, it is also important to talk to with caregiver and understand their view of the situation. In [Fig. 1](#), the different types of elder abuse are listed with potential "red flag" comments by older adults that may indicate abuse. For example, in abandonment, older adults may state: "I am all alone"; "I have no one to take me to the grocery store or pharmacy since my child has left"; or "I haven't seen my kids in months – they're so busy." In physical abuse, the physical examination often is the primary source of objective data. In the current health care structure, patients are often seen in their clothes rather than a patient gown and physical signs may be missed. Based on the older adult's chief complaint and further inquiry, the clinician may be able to ascertain that the history and the nature of the injury do not correlate as described. Home visits are often more revealing. The older adult's response to questions regarding lack of cleanliness in the home, lack of food and medication, and overall safety of the environment provide substantial information for further investigation. Older adults experiencing psychological abuse may be the least verbal. Thus, asking direct questions about incidents of psychological abuse (ie, yelling, ridicule) may be the best approach to detection.

Objective observations and clinical training can provide a lifeline to older adults experiencing any one of these type of abuse. We have divided the objective data into the physical, psychological, and sociologic/environmental manifestations. This biopsychosocial and environmental model will be helpful in any health care setting. Clinical manifestations of physical abuse have been discussed previously. It is important to complete a thorough skin examination. Psychological manifestations include evaluating the behaviors of both the older adult as well as the caregiver (if present). Do you observe impatience, anger, irritability, or "bullying" behaviors by the caregiver toward the older adult? Does the older adult patient seem to be more anxious, fearful, impatient, or nervous when the caregiver is in the room? These types of behaviors must be explored further through separate interviews with both the older adult and the caregiver. The sociologic and environmental manifestations may be red flagged in your electronic medical review. Is there a history of repeated emergency department or hospital admissions? Are electronic prescriptions filled? During geriatric home visits or interprofessional rounds, evidence should be documented regarding conditions such as disconnected utilities, financial strain, and level of concern

regarding available social services that may be affecting the older adults health maintenance and personal safety. This is especially important for older adults who depend on another for their care.

Remembering the elder abuse risk factors outlined in **Table 2** in conjunction with the older adult's subjective data and your objective biopsychosocial, physical, and environmental examination will lead to your assessment of this person's current health situation. In **Fig. 1**, we provide a limited assessment and plan of care depending on whether the patient is in immediate danger from abuse or neglect, has unexplained or inconsistent explanations for physical findings, has diminished decision making capacity or is not suspicious of elder abuse or neglect. This SOAP format provides a framework for daily clinical practice. It is easily incorporated into clinical practice so that increasing numbers of elder abuse can be detected and addressed.

SUMMARY

Elder abuse is often undetected, but nonetheless emerges as a critical medicosocial problem in an aging society. These cruelties are detrimental to the overall health, well-being, and survival of older adults. Despite advances over the last 20 years, society continues to face challenges that impede the protection of older adults from abuse. Factors such as ageism and the lack of health care professional training on elder abuse, uniform reporting standards, and clinical screening all diminish the chances for early detection and prevention. Protecting older adults from abuse requires finding ways to overcome these barriers in hopes of creating a society where aging is revered and those in the golden years can live safely without fear.

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