

Elder Abuse and Neglect: An Overview

Martin J. Gorbien, MD, FACP*, Amy R. Eisenstein, MA

*Section of Geriatric Medicine, Department of Internal Medicine, Rush University Medical Center,
710 S. Paulina Street, Chicago, IL 60612, USA*

The dramatic growth of the American elderly population has great implications for our health care system. The “demographic imperative” that has fueled the awareness of the needs of older adults has a major impact on issues related to social welfare, justice, and economics. There are 45 million people over the age of 60 and 3 million over the age of 85. Those over age 85 represent the fastest growing segment of the elderly population. The number of people 85 and older will be seven times higher in 2050 than it was in 1980. In 2030, 20% of the population will be elderly [1]. With this trend comes a segment of the population that is at risk for abuse, neglect, or self-neglect [2]. We are challenged to be aware of the many faces of elder mistreatment and to understand it in the broader context of domestic violence. All health care professionals working with older adults need to become familiar with the recognition, treatment, and prevention of elder abuse and neglect.

Background

Elder abuse was recognized in ancient societies. In *Old Age*, de Beauvoir analyzes Roman literature, which often describes its elders with derision and loathing [3]. King Lear’s message to his daughter Cordelia, “I am mightily abused. I should even die with pity...” is Shakespeare’s reflection of one regrettable father–daughter relationship [4]. In Jonathan Swift’s *Gulliver’s Travels*, the poverty and isolation of those over 80 is poignantly depicted and often quoted in gerontology classes [5].

* Corresponding author.

E-mail address: mgorbien@rush.edu (M.J. Gorbien).

Modern reports of elder abuse were first noted in the medical literature in England in 1975 when the *British Medical Journal* published a report of “granny battering” [6]. In the United States in the 1950s, Congress developed financial incentives for states to develop protective service programs, although cost and efficacy were questioned. Reports of abuse and neglect in nursing homes in the 1970s made way for a more systematic study of elder mistreatment as a result of a United States Senate Special Committee on Aging [7]. The 1981 United States House of Representatives Select Committee on Aging allowed victims of elder abuse to share personal testimony. The committee reported that “elder abuse is far from an isolated and localized problem involving a few frail elderly and their pathological offspring. The problem is a full-scale national problem which exists with a frequency which few have dared to imagine. In fact, abuse of the elderly by their loved ones and caretakers exists with a frequency and rate only slightly less than child abuse on the basis of the data supplied by the States” [8]. However, a federal elder abuse act failed to pass in that same year. Throughout the early 1990s, there was much activity at the national level as a result of the United States Department of Health and Human Services’ Elder Abuse Task Force and the creation of the National Institute on Elder Abuse. Despite the ongoing limitations of research in the area of elder mistreatment, the last decade represents a period of significant progress [9].

Defining elder abuse

Defining elder abuse and neglect has been influenced by governmental agencies and by researchers. The 1985 Elder Abuse Prevention, Identification and Treatment Act defined 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” [10]. Other definitions have been more needs oriented and tend to replace the terms “abuse” and “neglect” with the concept of the caregiver’s inability to meet the needs of the older adult or mistreatment of the older adult. Thus, acts of omission and commission are acknowledged. These definitions are less criminally oriented and therefore are less likely to create stigma. These definitions tend to relate elder mistreatment to theories of caregiver stress [11].

A consensus conference of the National Center on Elder Abuse (NCEA) and the National Elder Abuse Incidence Study (NEAIS) has standardized definitions as follows [12]:

- **Physical abuse:** The use of physical force that might result in bodily injury, physical pain, or impairment. Physical punishments of any kind were examples of physical abuse.
- **Sexual abuse:** Nonconsensual sexual contact of any kind with an elderly person

- **Emotional or psychologic abuse:** The infliction of anguish, pain, or distress
- **Financial or material exploitation:** The illegal or improper use of an elder's funds, property, or assets
- **Abandonment:** The desertion of an elderly person by an individual who had physical custody or otherwise had assumed responsibility for providing care for an elder or by a person with physical custody of an elder
- **Neglect:** The refusal or failure to fulfill any part of a person, obligations, or duties to an elder
- **Self-neglect:** The behaviors of an elderly person that threaten his/her own health or safety. The definition of self neglect excludes a situation in which a mentally competent older person who understands the consequences of his/her decisions makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety.

The standardization of these definitions is helpful for a variety of practical reasons and will likely have a positive effect on future study design. The area of self-neglect remains one of the greatest areas of variability among states.

Occurrence of elder abuse

It is believed that in the United States, over two million older adults are mistreated each year [13–15]. A landmark study by Pillemer and Finkelhor [14] revealed a prevalence rate of 32 per every 1000 adults. Physical abuse, verbal abuse, and neglect were found to be the most common types of mistreatment. Early studies found that 1% to 10% of seniors were victims of mistreatment [13,15]. All studies in this field acknowledge the ongoing belief that conceptual and methodologic flaws have led to our current underestimates [16,17]. Perhaps greater awareness of newer reporting guidelines will lead to increasingly improved estimates of the problem. There has been a 150% increase in reporting from 1986 to 1996 [18]. In 1996, the United States Administration on Aging study found that 551,011 persons over age 60 were victims of abuse, neglect, or self-neglect in a 1-year period [18]. In a study conducted in the Netherlands, four types of abuse (verbal aggression, physical aggression, financial mistreatment, and neglect) were studied in a cohort of community-dwelling residents aged 69 to 89. A prevalence rate of 56% was seen in this study group [19]. Limited data from Great Britain and Canada suggest similar trends [20,21]. A 4% incidence of abuse was noted in a small study completed in Maryland [22].

Risk factors for mistreatment include the following:

- Older age
- Lack of access to resources
- low income
- Social isolation
- Minority status

- Low level of education
- Functional impairment
- Substance abuse by elder or caregiver
- Previous history of family violence
- History of psychologic problems
- Caregiver stress
- Cognitive impairment

Most studies show that women are more commonly victims than men. Pillemer's study is one exception [14]. Women often suffer physical abuse and are almost always the victims in sexual abuse. Men are more likely to live with others, whereas women are more likely to live alone, increasing their risk for self-neglect. A growing population of seniors will increase the risk for all types of elder mistreatment, including exploitation and abandonment [11,23–26].

Intuitively, it should follow that elder mistreatment is on the rise given a rapidly growing at risk population. This belief is reinforced by data showing the increasing number of reports made to protective services agencies [27–30]. The need to have accurate information at a national level is a compelling reason to have a standardized and required format by which states share information with a federal entity. It has been estimated that in 1988 there were 140,000 reports of elder abuse and that by 1996 that number had reached 293,000 [31]. An 11-year, longitudinal study by Lachs [32] was among the first to describe patterns in use of adult protective services agencies.

The United States Administration for Children and Families and the Administration on Aging conducted the NEAIS. The study was designed to identify reported and unreported cases of elder abuse and neglect in 1996 [33]. Understanding the gap between reported cases and unreported cases is critical. One of the goals of the NEAIS project was to collect incidence data that was generalizable to the entire country. Critics are concerned that this methodology will lead to significant underestimates that will not provide sufficiently compelling data needed to effect public policy [34]. Studies looking at the prevalence of elder mistreatment are less common but would likely reveal larger numbers if we had sound estimates of all existing cases of elder abuse.

Self-neglect as a form of abuse

Self-neglect is described as “the result of an adult’s inability, due to physical or mental impairments or diminished capacity to perform essential self-care tasks including: providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; or managing financial affairs” by the National Association of Adult Protective Services Administrators [35]. Self-neglect presents one of greatest challenges in this field of study. Reports of

self-neglect have increased 150% between 1986 and 1996 [24]. Data from regulatory agencies suggest that over 70% of reports they receive reflect self-neglect. People over age 80 may represent close to half of the cases of self-neglect [24].

Many of the risk factors for abuse and neglect are relevant to self-neglect. Functional dependence, alcohol or drug abuse, age, isolation, and psychiatric illness are accepted risk factors for self-neglect. A 1997 study by Lachs [32] found that cognitive impairment, poverty, and being of a nonwhite race were independent predictors for self-neglect. Lachs' 1998 [36] study revealed that self-neglect and mistreatment contribute to increased mortality rate. In his cohort, 73% of the protective services reports involved self-neglect. After a 13-year follow-up period, 40% of those in the self-neglect cohort (53.2% in the mistreatment cohort) had died during this period. Only 17% of the noninvestigated cohort died in the same period. In all three groups, cardiovascular events were the most common cause of death. Those experiencing self-neglect were more likely to end up in long-term care facilities. This was the first longitudinal study designed to look at the association between elder mistreatment and mortality.

Recognizing and understanding abusers

A better understanding of those who abuse is important for many reasons. By better identifying potential abusers, we may be able to intervene earlier or prevent mistreatment. Abusers are most often the primary caregiver. Adult children (50%) are more likely to abuse more than spouses (20% to 40%). Males abuse more than females. The abuser is often financially dependent on the victim [26,29]. Understanding the relationship between the abuser and the victim helps frame elder mistreatment in the continuum of domestic violence.

Theories of caregiver stress have been central to the attempts to better understand those who commit elder abuse. In a 1990 study by Homer and Gilleard [37], caregivers were studied over a 6-month period; 45% of the caregivers admitted to some type of abuse. Alcohol abuse was the most common risk factor for physical abuse. Previous abuse and a poor, long-standing relationship between caregiver and patient were other significant risk factors. In contrast to other studies, the degrees of mental and physical disability were not significantly associated with abuse [38].

Since the 1980s, we have appreciated the complexities of the relationship between abusers and their victims. It was learned that caregiver stress was not found to be a primary explanation for elder mistreatment. Despite the nuance in the studies of victims and abusers, few conclusions can be drawn to codify these complex relationships. Support for the caregiver stress theory remains in light of concerns that it is too one-dimensional to explain what is seen in practice or in research findings. Critics point out that this theory identifies the victim as the problem validates the abuser and may leave the victim in harm's way. Anetzberger's [39] explanatory model proposes that, primarily, characteristics of the

perpetrator foster abuse; secondarily, characteristics of the victim, within a context, foster the abuse. She points out that caregiving is not the sole context. The model emphasizes the pathologies and perceptions of the perpetrator in her theoretical paradigm.

A 1989 study by Pillemer and Finkelhorn [40] provided additional support for caregiver personality issues as being important in the development of an abusive relationship. Their study compared theories of caregiver stress versus “problem relatives” (personality of the abusers). In this study, spouses—not adult children—were the larger group of offenders. Abuser deviance and dependence (and life stress in nonspouse caregivers) were far more important predictors of mistreatment by caregivers than were characteristics of the victims (eg, level of disability). This further serves to place elder mistreatment in the traditional realm of domestic violence while repositioning the important topic of caregiver stress in the menu of issues important to geriatric care.

Ramsey-Klawnsnik [41] proposes the following five types of offenders. This theoretical construct is based on experience in forensic investigations and clinical evaluations and treatment to victims and perpetrators of elder mistreatment.

- **The overwhelmed:** This group is well intentioned and generally qualified to provide care. When care needs exceed what they can provide, they may abuse verbally or physically. They do not look for victims.
- **The impaired:** This group is well intentioned but has problems that prevent them from delivering care. These caregivers may suffer from mental or physical problems that serve as barriers to providing adequate care. They may be unaware of the deficits in their care delivery. Neglect is more common in this group, and they may tend to control the victim through abuse.
- **The narcissistic:** These caregivers enter into caregiving relationships to meet their own needs. They are more likely to steal from seniors and neglect them. They see the relationship as a means to an end and may be attracted to nursing homes or centers where they can enter into relationships with vulnerable adults.
- **The domineering or bullying:** This group may feel entitled to exert power and authority. They may have narcissistic tendencies and often feel that the victim deserved the maltreatment. This type of offender may honor limits in other settings and has insight into the nature of the maladaptive behavior. This type of offender is prone to neglect and financial abuse. This type of offender may engage in sexual abuse.
- **The sadistic:** Offenders of this type often have sociopathic personalities and take pleasure in the mistreatment of their victim. Their abuse of others allows them to have feelings of power and importance.

These personality profiles may be helpful in research and clinical settings. This information has special significance for those responsible for hiring workers in long-term care facilities and other institutions.

Identifying elder abuse

The reporting of elder abuse remains a central concern in responding to elder abuse and neglect. Elder mistreatment is under-reported. For example, in Illinois there were 76,000 victims over age 60, but only 8000 reports were made [41]. All states have reporting mechanisms in place [42]. Much has been done to aggregate data at the national level. Tatara [29] pointed out the significant differences in definitions and eligibility among states. She estimated that there were 140,000 reports in 1988, which represented a 19.7% increase from 1986. Data from the NCEA revealed a reporting incidence of 293,000 by 1996. In 1991, the National Aging Resource Center on Elder Abuse surveyed the 54 jurisdictions and asked 12 basic questions regarding the agencies' local data. It represented the first study of this scope. Although many of the questions had low response rates, a great deal was learned about incidence, characteristics of abusers, victims, type of abuse, substantiation of reports, and self-neglect.

Wolf and Li [30] studied factors in reporting elder abuse within 27 geographic areas in Massachusetts in 1994. Four of 10 factors were found to be significant: lower socioeconomic status of the older adult, more community training of area professionals, higher agency service rating scores, and a lower community agency-protective services relationship score were predictors of higher reporting rates.

The AMA's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect represent a starting point for physicians to learn about their role in the recognition and response to mistreatment [9]. Despite being well positioned to report elder abuse, physicians report infrequently [43–47]. Despite reporter fear of being wrong, the majority of reports are substantiated. One large survey suggests that reporters are home care workers (27%), physicians and other health care professionals (18%), and family members (15%) [29]. A review of 5 years of elder abuse reports in Michigan found that physicians made only 2% of the reports; community members (41%), nonphysician health care providers (26%), social and mental health workers (25%), and law enforcement officials (5%) were more likely to report [48].

A 1997 survey of emergency medicine physicians revealed that of 705 respondents, only 31% were aware of a written protocol for reporting elder abuse, and they were largely unfamiliar with their state law. Unclear definitions, the inability to identify abuse and neglect, and concerns about resources were the common concerns raised in this study. Only 25% received instruction on the topic in residency training. Other common concerns raised by physicians include fear of being incorrect and disturbing the doctor-patient relationship [44].

Educating and encouraging physicians and other clinicians to learn to discuss the topic of domestic violence in late life can be helpful. **Box 1** provides questions that can serve as a starting point for conversations with patients. These discussions should be private, and the alleged abuser should not be present during the initial conversation.

Physical examination of the older adult may not always provide clear evidence of abuse or neglect. Fulmer and Ashley [16] attempted to clarify the clinical

Box 1. Elder abuse screening questions

- Has anyone at home hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?

Adapted from Elder mistreatment guidelines for health care professionals: detection, assessment and intervention, Mount Sinai/Victim Services Agency Elder Abuse Project. New York: 1988; with permission.

indicators of neglect. In their Elder Assessment Instrument, they included nine indicators: poor hygiene, poor nutrition, poor skin integrity, contractures, excoriations, pressure ulcers, dehydration, impaction, and malnutrition. Despite limits to this 1989 study, many of these items are important quality indicators for regulatory agencies that oversee hospitals and long-term care facilities. [Box 2](#) summarizes potential findings that may suggest abuse or neglect.

Elder abuse in special populations

There may be significant barriers in using the examination in patients with late-stage disease. The natural history of advanced neurologic disease (eg, Alzheimer disease [AD], Parkinson disease, and amyotrophic lateral sclerosis), cancer, or end-stage cardiopulmonary disease may lead to severe debility. Individuals who are immobile are at risk for many problems, such as pressure ulcers, pneumonia, and venous thromboembolism. Therefore, it is sometimes difficult to know what would have been preventable with adequate care. These issues are of particular importance for nursing home residents and nonverbal adults. Defining neglect against the backdrop of severe, chronic illness can challenge the most sophisticated clinician. Dementia and long-term care facilities have complex relationships with elder mistreatment and are addressed in detail elsewhere in this issue. Depression and dementia are common in long-term care facilities. Depression and dementia may be prevalent in elder mistreatment [40,49,50].

Box 2. Physical indicators of elder abuse*Physical abuse*

Bruises, wound, burns: unexplained, of various ages, patterns, well-defined shapes, immersion pattern
Rope or restraint marks on wrists or ankles
Traumatic alopecia or scalp swelling

Psychologic abuse

Habit disorder (sucking, rocking)
Neurotic disorders
Conduct disorder

Sexual abuse

Genital or anal pain, itching, bruising, or bleeding
Venereal disease
Torn, stained, or bloody underwear

Neglect

Dehydration, malnutrition
Poor hygiene
Inappropriate dress
Unattended physical or medical needs
Extensive pressure ulcers
Excoriations
Fecal impaction

Long-term care facilities have been a central focus of concern with regard to elder mistreatment since the 1960s. Concerns of the privation of residents' rights and substandard care have prevailed since that time. Anecdotes has often prevailed because there have been formidable barriers to research of any kind in this setting. In 1973, Kahana [51] wrote: "Those few accounts which look at the quality of life in institutions for the aged at close range tend to conjure up images of Dante's *Inferno*. . . . Nevertheless, there are no hard data on the prevalence of inhumane treatment in various institutional settings. Consequently there is the possibility that we are interpreting the isolated or occasional event as the norm." It is recognized that nursing home residents are increasingly dependent (Table 1). It is not uncommon that nursing home residents may be

Table 1
 Characteristics of nursing home residents

Characteristics	Percent
Aged ≥85 yr	49
Nonwhite	9
Receives assistance with ≥3 ADLs	83
Mild to moderate cognitive impairment	71
Exhibits physically aggressive behaviors	9
Exhibits any behaviors (eg, verbally or physically aggressive, resists nursing care, socially inappropriate)	30

Abbreviation: ADL, activities of daily living.

Data from Krauss NA, Altman BM. Characteristics of nursing home residents-1996 (AHCPR pub No. 99-0006). Rockville, MD: Agency for Health Care Policy and Research. MEPS Research Findings No. 5.1998.

“unbefriended elders.” A population of elders without meaningful advocates is growing [52].

Since the 1960s, qualitative studies describing mistreatment in nursing homes appeared in journals as case reports. It was difficult to know whether these were observations of isolated incidents or significant trends. A 1984 article by Monk [53] analyzed federal and state data and revealed that these were underestimates. A 1989 study by Pillemer and Moore [40] presented data from a random sample of 577 nurses and nursing aides from long-term care facilities. Self-report from staff showed psychologic, physical, and verbal abuse was not uncommon. Thirty-six percent of respondents had witnessed at least one act of physical abuse in the previous year.

A GAO report suggests that 50% of reports of physical or sexual abuse in nursing homes are not received until 2 or more days after the incident has been discovered. GAO data underscore the observation that the penalties for abuse in these institutions are often mild [54]. The need to develop reliable programs to screen potential nursing home employees remains a pressing issue.

Employees working for low wages in a stressful environment who are the hands-on caregivers are likely at high risk to become abusers. Twenty years after the initial studies, many of the issues remain the same with regard to the workforce and the environment in long-term care facilities despite dramatic increases in regulatory oversight. These ongoing circumstances compel us to develop staff education programs that are intended to decrease mistreatment [55].

The special relationship that exists among dementia, elder mistreatment, and nursing home care are discussed in detail elsewhere in this issue. The prevalence of AD increases with age, and AD will affect 14 million Americans by the year 2040. Despite conflicting data, it is often thought to be a risk factor for abuse and neglect. The functional decline marked by cognitive and physical decrements eventually results in decisional incapacity and the need for 24-hour care and surrogate decision makers [56]. In the community setting, AD has been identified as a risk factor for family violence. A study of 184 community-dwelling patients with AD and their caregivers found that 5.4% of caregivers were violent toward

the patient and that there was 17.4% prevalence of violence. Aggressive behavior may be seen in 57% to 67% of patients with dementia [57].

Advanced AD is a common cause for nursing home placement. This population is particularly vulnerable because of the degree of dependency and associated behavioral problems. Falls, agitation, dehydration, malnutrition, and worsening physical health may be indicators of abuse and neglect. The natural course of AD and other primary progressive dementias often makes such declines difficult to interpret as to whether or not the status change is expected. The growing population of nursing home residents with dementia challenges a system that is already flawed and filled with risk factors for mistreatment.

There is a growing awareness that the causes of death of nursing home residents are often unknown. Deaths of individuals with long-standing, chronic illness with multiple comorbidities often go uninvestigated. A study of 2400 deaths in Arkansas nursing homes found 50 cases of suspected abuse or neglect. There is increasing recognition that there may be a much larger role for forensic studies in the unexplained deaths of older adults from long-term care centers and from the community [58].

Innovative examples in nontraditional nursing home care offer promise with regard to the prevention of elder abuse in the long-term care setting. The Pioneer Network model is intended to form collaborative partnerships among stakeholders in long-term care: residents, families, resident advocates, staff, and surveyors. This management style is intended to promote well-being for staff through mentorship and relationship building [59]. The Coalition for the Rights of the Infirm Elderly has developed training methods for nursing home personnel to prevent abusive behavior. Limited data have revealed less abuse and burnout and fewer conflictual interactions with residents [55]. The Wellspring Model for Improving Nursing Home Quality has demonstrated enhancement of care and relationship through education and support of front-line staff [60].

Future implications for the health care team

The core philosophy of geriatric medicine is reflected in an ongoing commitment to interdisciplinary care. The effectiveness of team care has been shown in a variety of settings. As suggested by Lachs [46], if we begin to think of elder abuse and neglect as a geriatric syndrome, it follows that the same analytic and collaborative approach will be helpful. Screening tools need to be developed for identifying domestic violence in later life in the same way we have developed tools for many of the other geriatric syndromes. These basic principles are easily taught to students in all disciplines.

Frail, older adults with complex needs rely not only on the contributions of a variety of health care professionals but also on new team members that may include representatives from the legal, financial, and protective service communities [61,62]. Dyer's model program [63] was created to treat elder neglect. It represents an effective and successful example of collaboration between a geri-

atrics team and APS workers by incorporating essential elements of geriatric assessment in the evaluation of neglect. They demonstrated that isolated seniors might be more agreeable to comprehensive geriatric assessment than to traditional psychiatric evaluation. This has great implications for the growing population of unbefriended elders with questionable decisional capacity. Dyer identified the need for culturally sensitive approaches to the evaluation of neglect.

Geriatricians are appropriate leaders in the evaluation of potential abuse and neglect victims because they are trained in the interface of medical and psychiatric issues and are vigilant in recognizing and analyzing syndromes that lead to functional decline in the broadest sense. They are also sensitized to clinical findings that may suggest mistreatment. Comprehensive geriatric assessment is often appropriate for older adults who are being investigated for mistreatment because the medical piece of the evaluation is often missing from the traditional evaluation [64,65]. The utility of an expanded concept of the geriatric assessment team holds great promise. It is essential that we succeed in getting more people to join the team. "Abuse may go undetected until observant professionals intervene" [66].

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