

# Elder neglect and abuse

## A primer for primary care physicians

Jeffrey M. Levine, MD

Elder neglect and abuse represent a widespread, largely undiagnosed problem in the United States. Factors contributing to misdiagnosis and underreporting include denial by both the victim and the perpetrator, clinicians' reluctance to report victims, disbelief by medical providers, and clinicians' lack of awareness of warning signs. Physical abuse is most recognizable, yet neglect is most common. Psychological and financial abuse may be more easily missed. Elder neglect and abuse have many clinical presentations, ranging from the overt appearance of bruises and fractures, to the subtle appearance of dehydration, depression, and apathy. Risk factors are varied and may be categorized by victim or perpetrator. Dependency, on the part of the victim or perpetrator, and caregiver stress are frequent common denominators in abusive situations. Increasingly, institutionalization is recognized as a risk factor for neglect and abuse. Most states require primary care providers to report suspected elder abuse. Awareness of the risk factors and clinical manifestations allows primary care physicians to provide early detection and intervention for elder neglect and abuse.

Levine JM. Elder neglect and abuse: A primer for primary care physicians. *Geriatrics* 58(Oct):37-44.

**Key words:** Neglect • abuse • ageism • Diogenes syndrome

**E**lder neglect and abuse, which can take many forms, represent a widespread but largely hidden problem in the United States: one recent study estimates that 84% of cases are not reported. Whereas studies show

prevalence varies from 3 to 5%, the Senate Special Committee on Aging estimates upwards of 5 million older Americans are abused or neglected every year.<sup>1</sup>

Public recognition of elder abuse as a problem is relatively recent; its appearance in the medical literature only began within the past 30 years. The results of elder abuse are devastating and can include fractures, depression, dementia, malnutrition, and death.<sup>2,3</sup> Primary care providers are in a key position to prevent and detect abuse and neglect as well as intervene and treat patients suffering from the consequences.

Using a case study approach, this article will review sociodemographics; definitions of abuse and neglect; risk factors; detection, intervention, and

reporting; as well as abuse in institutional settings.

### Sociodemographic factors

Sociodemographic factors contributing to elder abuse include:

- intra-family stressors, such as separations and divorce, and financial strains
- decreasing importance of traditional age roles, including ageism and loss of respect for aged persons
- increased life expectancy, and
- advances in pharmaceuticals and medical technology that prolong years lived with chronic disease.<sup>4</sup>

The psychodynamics of elder neglect and abuse also contribute to underreporting and make the diagnosis difficult.<sup>5</sup> Both victim and perpetrator may downplay the existence or seriousness of the problem. The victim might be overwhelmed, embarrassed, or physically unable to ask for help. In addition, denial is common in victims, perpetrators, and even medical staff. Health professionals may minimize complaints or symptoms because of disbelief, fear of accusing the perpetrator, failure to recognize symptoms, or reluctance to deal with the issue.<sup>6</sup> Contributing to the problem of underreporting is ageism—an ingrained attitude that includes minimization of the older person's problems and lack of concern for their rights and needs.

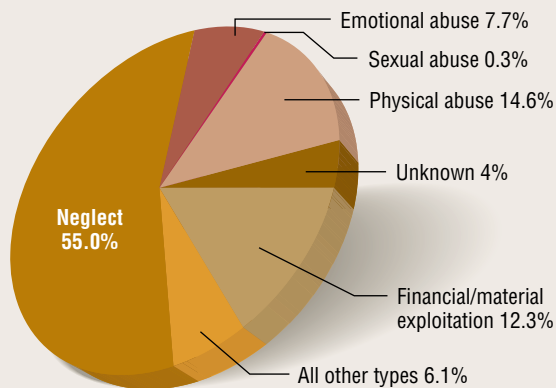
### Defining neglect and abuse

Elder neglect and abuse take many forms, and specific classifications may

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Disclosure: The author has no real or apparent conflicts of interest related to the subject under discussion.

**Figure. Types of domestic elder abuse (1996)**



Source: Adapted from National Center on Elder Abuse. Elder abuse information series no. 1 at [www.elderabusecenter.org/pdf/basics/fact1.pdf](http://www.elderabusecenter.org/pdf/basics/fact1.pdf)

vary among authorities and states (figure). Definitions of abuse (table 1) may be based on birth cohorts, cultural background, and ethnic beliefs. Paradoxically, victims may not even define their experience as abuse.<sup>7</sup>

Neglect is the intentional or unintentional withholding of food, medication, or other necessities that result in the older person's failure to thrive. In the nursing home, neglect is defined by federal statute (42 CFR § 488.301) as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." In the community, definitions for elder abuse vary from state to state, a fact that has made research on this issue more challenging. Neglect accounts for more than one-half of all reported cases.

Self-neglect is behavior that threatens the person's own health or safety. Because self-neglect constitutes almost 50% of the Adult Protective Services caseload, experts have argued for its inclusion in definition and studies of elder abuse.<sup>2</sup>

Physical abuse is any violence—including hitting, striking with objects, slapping, grabbing, or otherwise causing bodily injury.

Psychological or emotional abuse is the infliction of anguish or distress through threats, verbal aggression, intimidation, humiliation, harsh orders, or other

forms of verbal harassment. forms of verbal harassment.

Sexual abuse is non-consensual sexual contact of any kind. It may be included as physical abuse or categorized separately.

Medical abuse is the intentional withholding or improper administration of medications or other necessary treatments.

Financial or material abuse includes theft (cash, social security checks, personal prop-

erty), misappropriation of funds, coercion (such as forced amendment of wills or deeds), or other misuse of the person's income or other financial resources.

Violation of rights is the deprivation of any inalienable right, such as personal liberty, assembly, speech, privacy, or the right to vote. In nursing homes, this term is very broad and can include the right to medical services, choice of physician, right to remain in the facility, and freedom from physical restraint (42 CFR § 483.10). In nursing homes, for example, tying a resident down without proper assessment or justification is a violation of the resident's rights (42 CFR § 483.12).

In the nursing home, abuse is defined through the Interpretive Guidelines for Surveyors.<sup>8</sup> These were developed by Centers for Medicare and Medicaid Services (formerly named Health Care Financing Administration) to implement Chapter 42 of the Code of Federal Regulations, also known as Nursing Home Reform Amendments of the Omnibus Budget Reconciliation Act of 1987.

### Risk factors for self-neglect

Nearly one-half of all abuse cases and two-thirds of neglect cases that are investigated among older people involve self-neglect.<sup>9,10</sup> Self-neglect occurs when these adults are not willing or not able to perform essential self-care tasks such as:

- providing food, clothing, adequate shelter

- obtaining adequate medical care
- obtaining goods and services necessary to maintain physical and mental health, well-being, personal hygiene, and general safety

- managing financial affairs.

Poor overall self-care is a major indication of self-neglect. Specific signs to look for include:

- dehydration
- malnutrition
- hypothermia/hyperthermia
- excessive dirt or odor
- hazardous, unsafe or unclean living conditions
- inadequate or inappropriate clothing

- absence of needed eyeglasses, hearing aids, dentures, or prostheses

- unexpected or unexplained deterioration of health

- bedsores

- signs of excessive drugging, refusal to take medication, or other drug misuse.

Risk factors for self-neglect include:

- living alone

- dementia

- depression, bereavement, isolation

- poverty

- impairment in activities of daily living (ADLs) or instrumental activities of daily living (IADLs)

- alcohol abuse

- psychiatric disorder, developmental disability, lifelong eccentricity, or personality problems.

More women than men neglect themselves. However, this finding may be related to the fact that more women than men live alone.<sup>11</sup>

### Case example: Self neglect

A physician performed a home visit on Mr. J, an 83-year-old who refused to obtain medical care. Mr. J lived alone in a fifth floor "walk-up" apartment and had a long beard and obvious chronic skin rash. His wife had died several years earlier and his children lived in another state. The apartment was stacked from floor to ceiling with

**Table 1** Definitions of abuse for nursing homes

<b>Abuse</b>	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (42 CFR §488.301). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.
<b>Verbal abuse</b>	The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
<b>Sexual abuse</b>	Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
<b>Physical abuse</b>	Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.
<b>Mental abuse</b>	Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation.
<b>Involuntary seclusion</b>	Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative.

Source: American Health Care Association. The Long Term Care Survey. Washington DC: American Health Care Association, May 2001: Federal tag 223.

**Table 2** Routine screening questions for elder abuse

Has anyone at home ever 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?

Source: American Medical Association, Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, [www.ama-assn.org/ama1/pub/upload/mm/386/elderabuse.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/386/elderabuse.pdf), last accessed September 9, 2003.

years of accumulated trash, books, pizza boxes, and broken furniture. A narrow path wound from room to room between mountains of moldy objects, to the cot on which he slept. Mr. J reluctantly agreed to visit the physician, but continued to be uncooperative with medical management such as blood tests and medications.

**Author comment:** The condition of extreme self-abuse is called Diogenes syndrome, after the Greek philosopher who scorned civilization and lived in a tub.<sup>12</sup> Causes include personality fac-

tors, loneliness, and stress, and persons often have conditions such as malnutrition and other chronic diseases. Prognosis is poor, and intervention options are limited when the patient is cognitively intact and refuses all help.

**Risk factors for abuse**

Elder abuse is psychodynamically and medically complex, and many factors contribute to its occurrence. General risk factors can include history of family violence (where abuse is learned in the home and passed from one gener-

ation to the next).<sup>6</sup> Disruptive behaviors, such as the wandering, nocturnal agitation, and aggression, often present in persons with Alzheimer's dementia, can trigger caregiver violence.<sup>13</sup> One approach to grouping risk factors distinguishes caregiver/perpetrator and the victim.<sup>14</sup>

**Caregiver risk factors** can include stress or strain, physical or emotional exhaustion or both from responsibilities associated with providing care for elder persons. Mental illness, alcoholism and substance abuse are common contributing factors. Relatives who are dependent on the older person for financial assistance or housing have a greater risk of becoming abusive.<sup>2</sup> Often, care of the aged person in a family ends up with the least socially integrated adult child who might be unemployed or have other psychosocial stressors that render him or her more prone to become an abuser. If suspicion of abuse is raised, primary care providers should screen families or caregivers for these factors.

**Victim risk factors** include poor health, inability to perform activities of daily living, and cognitive impairment. Living with others places the older person at risk for physical abuse, whereas

**Table 3** Warning signs of elder abuse

- △ Delay between injury or illness and seeking medical attention
- △ Disparity in explanation between patient and suspected abuser
- △ Implausible, bizarre, inappropriate, or vague explanation of injury
- △ Laboratory findings inconsistent with stated history
- △ Unexplained bruises, fractures, lacerations, abrasions
- △ Gross inattention to nutrition and/or hygiene
- △ Apathy, depression, or worsening dementia
- △ Injuries in various stages of healing
- △ Decubitus ulcers
- △ Lack of compliance with medical regimen
- △ Bleeding gums, poor dentition and oral hygiene
- △ Weight loss, malnutrition, and vitamin deficiency

Source: Created for Geriatrics by JM Levine, MD, based on information in references 2, 16, 17, and 18.

living alone is shown to increase the risk for financial abuse. Further, socially isolated persons are more likely to be victims of abuse because of decreased likelihood that abuse will be detected and stopped. Lack of community support can increase risk because of the contribution to caregiver stress, frustration, and burnout.<sup>5</sup>

### Case example: Physical abuse and neglect

A 56-year-old man brought his father to the doctor because he “had fallen down the stairs.” Examination revealed a thin, 78-year-old man with poor hygiene, a black eye, and multiple bruises on his arms, legs, and scalp. The bruises were in various stages of healing. Laboratory studies revealed serum albumin of 2.3 (normal 3.5 to 4.5) indicating malnutrition. Chest x-ray revealed several rib fractures in different stages of healing.

Separate interviews were conducted with the son and father. Both denied any unusual circumstances of the injuries. The physician hospitalized the father and notified Adult Protective Services (an agency that exists by law in all states to investigate cases of possible elder abuse). At the home visit, the agency’s representative found the father’s bed covered with urine and feces and the refrigerator empty. The case was referred to a social worker who placed the father in a nursing home.

**Author comment:** The reality of elder abuse is that interventions satisfactory to all parties seldom occur. Forced placement of an older person into a strange environment may be unsatisfactory. The patient may prefer being at home—even in a potentially harmful situation. This makes intervention by the primary care physician or social worker more difficult, and should trigger referral to Adult Protective Services.

### Detection, intervention, reporting

Primary care providers are the front-line personnel who can offer prevention and detection of elder abuse. To improve the identification of cases and implement appropriate treatment and referral, the American Medical Association’s guidelines on elder abuse<sup>15</sup> call for routine questioning of all patients about abuse and neglect—even patients with cognitive impairment. Recommended questions appear in table 2.

The victim can present to the home-care nurse, emergency department, dentist, or physician’s office with overt or subtle manifestations. The most obvious signs are injuries at various stages of healing, but apathy, depression, or social withdrawal may be the only symptoms. Victims are sometimes too embarrassed, intimidated, or cognitively impaired to discuss what happens at home or may not realize they

are being mistreated.<sup>16</sup> Warning signs of elder abuse are presented in table 3.<sup>17,18</sup>

Once the clinician suspects a problem, he or she should conduct a complete physical examination with laboratory tests, such as complete bloodcell count, chemistries, and serum albumin, and imaging studies. A complete body check, including genitalia, can reveal ulcers, bruises, lacerations, or venereal disease. Suspicious findings can be confirmed by X-ray studies showing fractures in various stages of healing or laboratory values indicating dehydration or malnutrition. All investigations for elder abuse should include a structured cognitive assessment such as the Folstein Mini-Mental Status Examination.

### Case example: Sexual abuse

Mrs. S, a 78-year-old woman with mild dementia, was brought by her son to the emergency department for purulent conjunctivitis. A course of topical antibiotic drops did not cure the infection, and she was brought back. The physician ordered a culture of the eye discharge, which was positive for multiple-drug resistant gonococcus. The physician notified Adult Protective Services. An agency representative went to the home and found that the mother and son were sleeping in the same bed. Mrs. S was hospitalized immediately.

**Author comment:** Sexual abuse of the older person can be extremely subtle in its clinical presentation. Caseworkers require advanced skills to deal with the psychological complexity of these situations. Sexual abuse in the nursing home presents an entirely different set of circumstances, as the abuser is often a stranger employed by the institution.

Separate interviews must be conducted with the suspected victim and the caregiver because denial is almost always present; the patient should be asked about the nature and quality of the relationship with the caregiver and the conditions of the home. Interviews with the suspected abuser should offer empathy for the burdensome tasks of

## Internet Resources

### U.S. Administration on Aging

<http://www.aoa.gov>

Information for practitioners and professionals. Has extensive information of caregiver resources.

### National Citizen's Coalition for Nursing Home Reform

<http://www.nccnhr.org>

Provides information and leadership on federal and state regulatory and legislative policy, and strategies to improve nursing home care.

### National Center on Elder Abuse

<http://www.elderabusecenter.org/>

Collects data and provides data; conducts training and research, serves as an information clearinghouse.

### List of web resources and links

<http://www.seniorlaw.com/elderabuse.htm>

This page includes materials compiled by Lori Stiegel, Associate Staff Director, American Bar Association Commission on Legal Problems of the Elderly National Initiatives and Resources on Elder Abuse.

Source: Adapted from Marshall CE, Benton D, Brazier JM. Elder abuse: Using clinical tools to identify clues of mistreatment. *Geriatrics* 2000; 55(2):42-53.

caregiving and avoid accusatory language. Findings should be carefully documented in the medical record.

State statutes differ as to when elder abuse should be reported, as well as the type of mistreatment that triggers the report.<sup>19</sup> Reporting is voluntary in seven states: Colorado, Illinois, Iowa, Kentucky, North Dakota, South Dakota, and Wisconsin. Laws differ from state to state, and the reader is encouraged to determine specific local requirements.

Management priorities should emphasize the safety of the older person while respecting autonomy.<sup>2</sup> Hospitalization may be justified, but satisfactory options for the abuse victim can sometimes be limited. Referral can be made to Adult Protective Services.

### Abuse in institutional settings

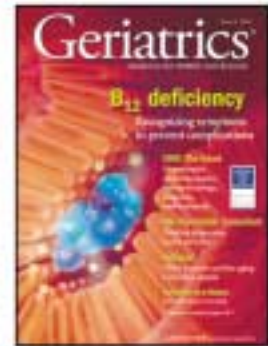
Institutionalization in nursing homes has recently been recognized as a risk factor for elder abuse.<sup>20</sup> Reasons include patient vulnerability, social isolation, and mental impairment. The institution may have poor employee relations, staff shortages, inadequate screening and training of employees, mismanagement, and staff turnover,

all of which can contribute to potential abuse. Regulations including the Nursing Home Reform Amendments of the Omnibus Budget Reconciliation Act of 1987 have done much to increase the quality of care in nursing homes. Unfortunately, the problem of neglect and abuse persists.<sup>21</sup>

Abuse in institutional settings presents specific challenges for detection and intervention, because many nursing home residents have lost their ability to complain or give a history. In the presence of extreme frailty and multiple chronic illnesses, poor outcomes such as malnutrition and pressure ulcers can occur even with the best of care. If there is a lack of family involvement, nursing home abuse may be suspected only by the emergency services physician or the mortician. To substantiate elder abuse in the nursing home, staff interviews in conjunction with review of medical records, incident reports, state surveys, and complaint files may be necessary. This process may only occur in litigation, long after the injury has occurred or the patient has died.

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has provided recommendations on management of elder abuse in nursing homes that include a statewide network of responsibilities and procedures for reporting and investigation.<sup>22</sup> Federal law (42 CFR § 483.13[c] [2-4]) mandates all nursing homes to report and investigate allegations of abuse.

## Case example:

### Nursing home abuse

Mr. Y was a 74-year-old man who had a stroke and flexion contractures of the upper and lower extremities and was fed via gastrostomy tube. After residing in Happy Trails Nursing Home for 10 months, he became febrile. Despite the nursing home's policies for prevention, there was no anti-pressure mattress, and turning and positioning was only sporadically performed. Decubitus ulcers were not recorded in the patient's medical records. However, by telephone the physician had ordered treatment with hydrocolloid dressings. Mr. Y's fever continued for 2 to 3 weeks without physician evaluation. When the patient was transferred to the emergency department, several necrotic ulcers were noted, one of which necessitated amputation of a lower extremity. A review of the patient's chart revealed inadequate documentation of his pressure ulcer, no physician evaluation, and no recommendation to turn or reposition Mr. Y in order to prevent wound development.

**Author's comment:** This case illustrates neglect in the nursing home, evidenced by inadequate attention to wound prevention and treatment. The facility deviated from its own policies by not providing proper wound documentation and pressure relief. The primary care physician did not evaluate the resident at the bedside, but rather provided care for a worsening wound by telephone.

## Conclusions

Neglect and abuse are serious issues for older Americans, for those who reside in the community as well as in long-term care institutions. Because of common comorbidity and chronic illness in this population, primary care

providers are frequently in the best position to diagnose, intervene and report potential victims. Indeed, social isolation and mobility limitations sometimes make the medical professional the only contact outside the home. Primary care providers are uniquely situated to provide screening and early detection. All caregivers who come into contact with older patients—whether in the outpatient setting, emergency department, nursing home, or home—should know the warning signs and be aware of reporting mechanisms. ☐



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