

# **Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum**

**Module # 8 : Elder Mistreatment**

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# **Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum**

## **Module # 8 : Elder Mistreatment, Neglect and Abuse**

### **Table of Contents**

	<b>Page(s)</b>
<b>I. Overview</b>	<b>1</b>
<b>II. Learning Objectives</b>	<b>1</b>
<b>III. Definitions</b>	<b>2</b>
<b>IV. Demographics</b>	<b>2</b>
<b>V. Forms of Elder Mistreatment</b>	<b>2</b>
<b>VI. Risk Factors for Elder Mistreatment and Abuse</b>	<b>4</b>
<b>VII. Elder Mistreatment Assessment</b>	<b>4</b>
<b>VIII. Elder Mistreatment Interventions</b>	<b>6</b>
<b>IX. A Unique Intervention Model</b>	<b>7</b>
<b>X. References</b>	<b>8</b>
<b>XI. Learning Resources</b>	<b>10</b>
<b>A. Screening Tool</b>	
<b>B. Case Studies</b>	
<b>1. Ms. R.</b>	
<b>2. Dr. S.</b>	

## **Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum**

### **Module #8: Elder Mistreatment**

**I. Overview:** Elder Mistreatment is a serious and prevalent health problem that affects between 700,000 to 1.2 million Americans. Elder mistreatment is a complex phenomenon that is often hidden and extremely difficult to detect without specific advanced training. The syndrome typically can include abuse, neglect, exploitation and abandonment of an older person and often results in tragic outcomes for the older victims. Social stigma, fear of retribution, and shame are barriers to reporting and intervening in abusive situations. The prevalence of elder mistreatment is increasing with the aging of America and without adequate training of health professionals and allied healthcare workers, needless suffering will continue and potentially increase.

### **II. Learning Objectives:**

1. Define “elder mistreatment” and “elder neglect”.
2. Describe the prevalence of elder abuse in the United States.
3. Describe the multiple forms of elder mistreatments.
4. Provide an overview of the risk factors for elder mistreatment.
5. Outline the steps of an elder mistreatment assessment.
6. Identify approaches to including elder abuse assessment in the traditional interdisciplinary team model of geriatric assessment.

### III. Definitions

- A. The American Medical Association's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect defines elder mistreatment as "the act of omission or commission that result in harm or threatened harm to the health or welfare of an older adult."<sup>1</sup> The term "elder mistreatment" is a general term for both elder abuse and neglect.
- B. Elder abuse can occur in a domestic setting, such as one's home or the home of a caregiver, or in an institutional setting, such as a nursing home, board and care home, or other health care or residential facility.<sup>2</sup>

### IV. Demographics

- A. It is estimated that approximately 4% of adults over the age of 65 are victims of elder abuse; furthermore, it is estimated that only 1 in 14 cases is reported.<sup>3</sup>
- B. The National Elder Abuse Incidence Study (NEAIS) indicates that approximately 450,000 older adults in domestic settings were abused or neglected in 1996.
- C. The largest percentage of perpetrators of substantiated reports of elder abuse is adult children of the victim at 47%, followed by the victim's spouse at 19%.
- D. Whereas physical, emotional, and financial abuse decreases with advancing age, the incidence of caregiver neglect increases with age. Women are the recipients of all types of elder abuse to a greater extent than men. Refer to the attached tables<sup>4</sup>.

### V. Forms of Elder Mistreatment<sup>5</sup>

- A. *Abuse* – This is also called "mistreatment" or "maltreatment" and is harmful behavior directed toward an older person by a family member or professional caregiver whom the older person trusts or depends on for assistance.
- B. *Neglect* – In this type of mistreatment, there is intentional or unintentional harmful behavior on the part of an informal or formal caregiver in whom the older person has placed his or her trust. Examples include the refusal or failure to carry out a caretaking responsibility such as withholding food, medicine, or aids (glasses, dentures), and actual abandonment of the older adult.
- C. *Active Neglect* – The caregiver refuses or fails to fulfill a caretaking obligation, including a conscious and intentional attempt to inflict physical or emotional distress on the elder; deliberate abandonment, or deliberate denial of food or health-related services.

- D. Passive Neglect – In this type of mistreatment, the caregiver unconsciously or unintentionally refuses or fails to care for the older person. Examples include abandonment, non-provision of food or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of the prescribed service.
- E. Physical Abuse - Physical mistreatment entails the infliction of physical pain or injury, physical coercion, or confinement against one's will. Examples include pushing, hitting, bruising, sexual coercion or molestation, force-feeding, and improper use of physical restraints or medications<sup>6</sup>
- F. Physical Neglect – The caregiver neglects to provide the goods or services that are necessary for optimal functioning. Examples include not giving needed health care, such as meals and water, physical therapy, and washing, and failure to provide such assistive devices as glasses, hearing aids, or canes.
- G. Psychological/Emotional Abuse– This type of mistreatment entails psychological and mental anguish and despair. Examples include insulting, ignoring, threatening remarks, mean jokes, and controlling behavior.
- H. Psychological Neglect– The caregiver fails to provide social or emotional stimulation and opportunities for social interaction, such as leaving the older adult alone for long periods of time. Other examples include ignoring requests of the older person and failing to give him news or information.
- I. Financial Exploitation – This is illegal or unethical exploitation and/or use of cash, credit cards, funds or other financial resources of the older person. Examples include coercing the individual to sign contracts or sign over assets or making changes in a will.
- J. Financial/ Material Neglect - In this type, the caregiver fails to use the available funds or resources which are needed to provide an optimal quality of life for the older person.
- K. Violation of Person Rights – The older person's rights and capability to make decisions for himself are ignored. Examples include denying privacy, autonomy in decision making with respect to health care and other personal issues (e.g., marriage), and forcible placement in an institution.
- L. Self-Abuse or Self-Neglect – This occurs when the older person commits any of the above activities himself.

## **VI. Risk Factors for Elder Mistreatment and Abuse<sup>7</sup>**

- A. Overwhelming burden of dependency on caregiver by older person for physical/emotional/financial support
- B. The more physically vulnerable who are often dependent on family members for physical care.<sup>8</sup>
- C. Physical, functional or cognitive problems or inordinate stress on caregiver.
- D. Mental illness, alcoholism, or drug abuse in the older person or caregiver.
- E. Financial or other family problems.
- F. Inadequate housing or unsafe conditions in the home.
- G. Unrealistic expectations of the caregiver.
- H. Over-extension of caregivers in attempting to care for both the older person and other family members.
- I. Social isolation of the older person—lack of active involvement of family and friends in older person's day-to-day life.
- J. Intergenerational violence or history of abuse in the family.

## **VII. Elder Mistreatment Assessment<sup>9</sup>**

- A. Assessing the Patient
  - 1. Elder assessment teams are usually made up of physicians, nurse practitioners, nurses, and social workers, with other professions, such as pharmacy, included in some instances. Given the complex nature of elder abuse, interdisciplinary teams can best address the multiple medical, social, psychological, and other issues that present themselves.
  - 2. Get history from the patient: include direct questions about mistreatment and look for indications of unusual confinement, sudden withdrawals or closing of bank accounts, excessive weight gain or loss, insomnia or excessive sleeping.

### 3. Physical Indicators of Mistreatment

- New and inadequately explained injuries such as bruises, welts, lacerations, fractures, rope marks or burns, pressure ulcers.
- Dehydrated or malnourished appearance.
- Lack of cleanliness, grooming, personal hygiene.
- Presence of head injury, hair loss, or hemorrhaging beneath the scalp. Signs of possible sexual abuse: discharges, bruising, bleeding, or trauma around the genitalia or rectum, unexplained venereal disease or genital infections.
- Laboratory findings indicating medication overdose or under medication.

### 4. Behavior of the Patient Indicating Mistreatment

- Acts overly medicated or overly sedated.
- Fear of speaking for oneself in the presence of caretaker; anxious to please.
- Anxiety, confusion, withdrawal, depression.
- Shame, fear, embarrassment.
- Little or no eye contact or communication.
- Explanation is not consistent with the medical findings.

### B. Assessing the Caregiver

- Threatening remarks and/or behavior
- Conflicting stories
- Insults, aggressive behavior
- Withholding of attention, security, affection
- Attitude of indifference or anger toward the older person

- Unusual fatigue, depression
- Obvious absence of assistance, or attendance
- Problems with alcohol or drugs
- Previous history of abusive behavior
- Contradictory and/or inconsistent explanations given by the patient and the caregiver

[See Learning Resource A: Elder Abuse/ Neglect Screening Assessment Tool]

### **VIII. Elder Mistreatment Interventions**

#### **A. Key Questions to Guide Intervention**

- How safe is the patient if I send him or her back to the current setting?
- What services or resources are available to help a stressed family?
- Does the elderly person need to be removed to a safe environment?
- Does this situation need an unbiased advocate to monitor the care and finances for this patient?<sup>9</sup>

#### **B. Reporting Mistreatment-**

Nearly all states require designated health care professionals to report suspected elder mistreatment to a state authority.<sup>10</sup>

#### **C. Community Resources Available to Victims-**There are a range of resources available, including: Case management services, protective services, support counseling services, victims services network, police services, District Attorney's offices, and legal services specializing in the elderly.

## **IX. A Unique Intervention Model:<sup>11</sup> Baylor College of Medicine**

A. Geriatric interdisciplinary teams focus on the overall condition of the patient and may be limited in ability to intervene in cases of abuse or neglect.

- Adult Protective Services specialize in assessment and intervention in cases of possible neglect or abuse—focus here precludes comprehensive medical assessment
- In light of above factors, Baylor College of Medicine Geriatric Program has collaborated with Adult Protective Services (APS) Division, making an APS representative a member of the Geriatric Interdisciplinary Team
- Interdisciplinary care plan now includes findings from APS assessment
- Assessments are carried out both in outpatient geriatric clinic and in the older clients' homes
- This model fully addresses 3 vital domains of older adult's life: 1) medical problems, 2) social milieu, and 3) functional status. Medical and APS assessments complement each other to address each domain.

## X. References

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16. Ibid. p. 28.

**XI. Learning Resources:**

**Learning Resource A : Elder Abuse/Neglect Screening Assessment Tool**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Introductory comment: No matter how well people get along there are times when they disagree on major decisions, get annoyed about something the other person does, or just have arguments because they are in a bad mood or for some other reason. People also use many different ways of trying to settle their differences. I am going to read you some things that people do when they have arguments or problems, and ask you whether this has ever happened to you.

<u>Ask patient directly:</u>	Yes	No	Comments
1. Has anyone ever hurt you?	_____	_____	_____
2. Has anyone ever touched you when you didn't want to be touched?	_____	_____	_____
3. Has anyone forced you to do something against your will?	_____	_____	_____
4. Has anyone ever taken anything that was yours without permission?	_____	_____	_____
5. Have you ever given anything away even though you really didn't want to?	_____	_____	_____
6. Does anyone ever talk or yell at you in a way that makes you feel lousy or bad about yourself?	_____	_____	_____
7. Are you afraid of anyone?	_____	_____	_____
8. Has anyone ever threatened you?	_____	_____	_____
9. Has anyone ever refused to help you take care of yourself when you needed help?	_____	_____	_____
10. Has anyone used your money in a way you did not like?	_____	_____	_____

	Y	N	Comments
11. Do you have ready access to a telephone?	___	___	_____
12. Do you live with anyone, or have any close family members who abuse drugs or alcohol, or have a psychiatric or emotional illness?	___	___	_____
13. Do you feel that your basic needs for food, clothing, shelter and medications are adequately available to you all the time?	___	___	_____
14. Are you able to go out of your house when you want?	___	___	_____
15. Are you happy with how often you see your relatives and friends?			

If any answers to questions 1-11 are “yes” or 12-15 are “no”, please elaborate and consider consulting the Elder Abuse Team.

**Physical Assessment**

Describe patient’s general appearance (e.g., inadequate or inappropriate clothing, dirty or odorous): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Check if any of the following are present:**

<input type="checkbox"/> Bruises	<input type="checkbox"/> Rashes
<input type="checkbox"/> Fractures	<input type="checkbox"/> Scars
<input type="checkbox"/> Burns	<input type="checkbox"/> Welts
<input type="checkbox"/> Lacerations	<input type="checkbox"/> Punctures
<input type="checkbox"/> Abrasions	<input type="checkbox"/> Decubiti
<input type="checkbox"/> Other	

**Stages of decubitus/pressure ulcers:**

I. Redness not resolving after 20 minutes following relief of pressure, epidermis intact.
II. Break in skin involving the epidermis. May appear as a blister with erythema and/or induration.
III. Skin break exposing subcutaneous tissue.
IV. Skin break exposing muscle and bone.

**Dating of Bruises:**

Date	Appearance
0-2 days:	Swollen, tender
0-5 days:	Red-blue
5-7 days:	Green
7-10 days:	Yellow
10-14 days:	Brown
2-4 weeks:	Clear

**Status of Assistive Devices:**

If patient needs and does not have devices, or patient has but does not use devices, this may be evidence of neglect.				
Device	Needs	Has	Uses	Explanation
Dentures				
Cane				
Walker				
Hearing Aid				
Other				

**Ask Patient Directly:**

Has anyone ever prevented you from obtaining or using aides?

\* Yes \_\_\_\_\_ No \_\_\_\_\_

\* If yes, please explore further and consider consulting the Elder Abuse Team.

**Reference:**

Written by: Pamela Ansell, MSW, Mount Sinai/Victim Agency Abuse Team Project, New York City.; Judy S. Bloom, MPA, Montefiore Medical Center Elder Abuse Project;  
Karl Pillemer, PhD, University of New Hampshire's Family Research Laboratory;  
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This tool is adapted from a research survey titled "Family Relationship of the Elderly," developed by the Center for Survey Research, University of Massachusetts-Boston and the center for Family Studies University of New Hampshire (Fall, 1985).

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## **Learning Resource B: Two Case Studies**

### **Case Study #1: Ms. R**

Ms. R is an 85-year old woman who lives in a New York City apartment with her 60-year-old daughter, Ms. S. Ms. R was born in Puerto Rico and moved to the mainland shortly after she was married. All four of her children were born in New York. Three of Ms. R's children are married, and two of them along with their spouses, retired and moved to the Miami area a few years ago. One daughter lives in central New Jersey. Ms. R has 11 grandchildren, and five of them live within an hour's trip of New York City. Ms. S has never married, and after her mother was widowed, Ms. S gave up her own apartment and moved in with her mother.

Recently, Ms. R developed a high fever and was diagnosed with pneumonia. Her physician admitted her to the hospital, where her daughter sits at her bedside for most of the day. When you speak to Ms. S, she tells you that Ms. R frequently seems to "lose track of time." In fact, before admission to the hospital, Ms. R was awake much of the night at home and slept during the day. As a result, Ms. S says she herself is very tired most of the time and is experiencing difficulty at work.

After a few days of intravenous therapy and antibiotics, Ms. R recovers from her pneumonia, and plans are made for her to be discharged home. Ms. S expresses concern to you that her caregiving responsibilities are becoming somewhat overwhelming, and she is feeling very stressed.

\*Source: Mariano C, Gould E, Mezey M, Gulmer T, eds. Best Nursing Practices in Care for Older Adults: Incorporating Essential Gerontologic Content into Baccalaureate Nursing Education. 2<sup>nd</sup> ed. New York: The John A. Hartford Foundation Institute for Geriatric Nursing, Division of Nursing, School of Education, New York University; 1999.

### Case Study #2: Dr. S.

Dr. S. is a 74-year-old divorced woman, mother of one son, retired neurologist, who was referred to the Geriatrics Practice by her orthopedic surgeon for general evaluation and medical care. Dr. S.'s medical diagnoses included hypothyroid disease, severe arthritis of the hip, and memory loss. Her son accompanied Dr. S. to her medical visit. She was agitated, tearful, uncooperative with a physical examination, and unable to provide a history. Her son was cooperative but appeared unrealistic about his mother's capabilities.

Dr. S. was subsequently seen in the Gero-Psychiatry Clinic and hospitalization was recommended. During this admission, past medical history came to light indicating physical and emotional abuse by her son. Protective Services for Adults previously knew the case and Guardianship procedures were already underway.

The patient's son was upset by her hospitalization and repeatedly requested that his mother be discharged. He denied abusing his mother and felt that other people were just trying to take her money. Dr. S. was discharged of the care of a home attendant and a guardian was instituted. The son was given limited supervised visitation privileges.

Dr. S. was started on physical therapy in her home. Physical therapists were unable to work with the patient due to her dementia and agitation. A private therapist, experienced in working with dementia patients was recommended but the guardian would not pay for the services. The guardian subsequently requested that the patient's psychotropic medications be increased to help calm her down, as she could no longer afford to pay the two 12-hour home attendants.

Questions:

1. Should we have been able to detect a history of abuse on the day of the initial visit?
2. Do we feel that the guardian was acting in the best interest of the patient?
3. What role does the medical team have in contacting the courts or Protective Services for Adults to advise about concerns about guardians and financial difficulties?

Source: Paris, B and Kahan, F. Geriatric Medicine Update and Board Review. *Clinical Workshop: Elder Mistreatment*. 2000

