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Institutional abuse of older adults

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Summary

This report was prepared amid increasing concerns about the care of elderly patients in long-stay settings and newspaper criticism of doctors' attitudes to older people. Abuse is maltreatment as a single or repeated act, or neglect; it may be intentional or owing to ignorance or thoughtlessness, by a person or persons in a position of power. It covers five domains: physical, sexual, social,

psychological and financial. It is underrecognised and underreported. Elder abuse takes many forms ranging from subtle interactions to acts that are frankly criminal. What links the range of behaviours is that they occur in situations in which the victim is de-humanised. The abuser relates through power in the absence of clear thinking. Institutional abuse includes individual acts or omissions and managerial failings in which the regime of the institution itself may be abusive.
The subject of elder abuse has generated an increasing body of literature, but little specifically about the role of doctors. This report aims to define the role of doctors in the prevention, detection and management of abuse in institutions, to raise awareness, improve practice and to extend an understanding of a social, organisational and individual psychodynamic perspective to the aetiology and manifestation of abuse. Some abusive behaviour is consciously enacted. The majority is out of ignorance, unthinking and ageism, factors that can be addressed in training.
Doctors are in a position to influence significantly the culture and atmosphere of the units where they treat patients. Old age psychiatrists have a responsibility to take the lead in prompting an examination of ageism and the capacity for abuse in the homes and wards where they work.
The report concludes with a list of recommendations for organisation, for the clinical setting and for training. The recommendations are applicable to other vulnerable people in institutions.

Introduction

The subject of elder abuse has generated an increasing literature over the past two decades, but has only recently achieved a place on the political agenda with the publication of *No Secrets: The Protection of Vulnerable Adults* (Department of Health, 2000). Old age psychiatrists and their teams have a particular responsibility in the identification and prevention of elder abuse; those who have direct contact with the elderly mentally ill in institutions need to carefully examine the factors that foster ‘the corruption of care’ (Wardhaugh & Wilding, 1993).
In the absence of a legal framework, many attempts have been made to define abuse of elderly people (Kingston & Reay, 1996; Brammer & Biggs, 1998), some utilising definitions of child abuse (Stevenson, 1999). For the purpose of this report, abuse is maltreatment as a single or repeated act, or neglect; it may be intentional or owing to ignorance or thoughtlessness, by a person or persons in a position of power. It covers five domains: physical, sexual, social, psychological and financial. The circumstances may range from minutely subtle interactions or tone of voice, to acts that constitute a violation of human and civil rights.
Elder abuse takes many forms (Appendix I); it is underrecognised and underreported. Rarely, it occurs as an isolated event and may persist over extended periods. Several types of mistreatment may occur simultaneously.

The word ‘abuse’ may be a euphemism for some acts that are criminal (Griffiths *et al*, 1997). What links the range of behaviours is that they occur in situations in which the victim is de-humanised and seen as an extension of and solution to the abuser’s needs. The abuser relates through power in the absence of clear thinking. Elder abuse in the home receives far less attention than other forms of domestic violence; even so, there is much more in the literature on abuse occurring at home rather than in institutions. It is easier to think of it as a grim secret for families with problems rather than an issue that affects professionals. Biggs (1996) notes that the Department of Health guidelines, *No Longer Afraid: The Safeguard of Older People in Domestic Settings* (1993), regard abuse as a domestic phenomenon. Perhaps this was a great institution’s avoidance of the issue, positioning it firmly within the family. Elder mistreatment in a family setting is conceptualised as abuse, whereas in the environment of an institution it is a ‘quality’ issue. Glendenning (1997), in reviewing findings of inquiries and tribunals under the 1984 Registered Homes Act, notes that “there is chilling evidence” that elderly people living in care are more likely to be at risk than those who live in the community.

This report will deal specifically with abuse that occurs in the setting of care in institutions such as residential and nursing homes and hospital wards.

It is not merely increasing age that makes people vulnerable. There are dangers in seeing older people only as potential victims; however, health services for

those over the age of 65 years see many patients who may be mentally incapacitated and others who are vulnerable through physical frailty and dependency. Those in institutional settings are the most vulnerable, even more so than children, and the most likely to fall prey to de-humanising attitudes.

There is a need to put institutional abuse into a social context. Although issues of social policy and provision of services are beyond the scope of this report, it could be considered that a culture that spends so little of its gross national product on health and social care is abusive. However, the main focus of the report will be mistreatment by those who are in breach of both a direct obligation to care and an expectation of trust. It is a problem for health service wards (see Camden & Islington Community Health Services NHS Trust, 1999), social services homes (see Gibbs *et al*, 1987) and the growing private sector (see UK Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1994). Institutional abuse includes individual acts or omissions and managerial failings in which the regime of the institution itself may be abusive (Gilleard, 1994).

Abuse does not only occur in rare, dramatic and well-publicised incidents; it is a common part of institutional life. Pillemer & Moore (1989) conducted a telephone survey of 577 nurses and care assistants working in American nursing homes: 36% of the staff had witnessed physical abuse, with 10% admitting to committing one or more act themselves; and 81% had witnessed psychological abuse, 40% admitting to it personally. In the UK, abuse allegations made to the

UKCC average about 1000 annually. Half of these relate to physical, verbal or sexual assault. In 1998, 84 nurses lost their registration; more offences occurred in nursing homes than anywhere else (*Nursing Times*, 24 February 1999).
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Aetiology

The causes of abuse are complex and varied. There is unlikely to be a single reason but a combination of factors. Even in the grossest cases, personal malevolence is not an adequate explanation, although individual psychopathology cannot be ignored. Multiple factors need to be considered.

Personal factors

Carers for patients who are seriously disabled psychologically need particular personal skills. Their patients need them to be able to make sense of complicated communications without becoming overwhelmed, either by despairing or punitive feelings. Some of these skills may be learned, others seem to be dependent on personal qualities, for example, the capacity to tolerate frustration and contain anxiety. The abuser may be a bully expressly targeting an easy victim, or someone with a rigid 'jobsworth' attitude, but more commonly and more understandably may be someone who started out without malevolence in mind but who has become corrupted by fear, hatred or ignorance.

Bennett *et al* (1997) remind us of the paucity of empirical evidence in this field, and that which exists is from the USA. There is some evidence to suggest that those who abuse people often misuse alcohol or drugs and have psychiatric or personality difficulties and relationship problems. Pillemer & Moore (1989), in their survey of nursing home staff in America, found that staff were more likely to commit physical abuse if they viewed the patients as childlike and "… like children they need discipline from time to time". These staff also reported that they frequently thought about resigning – perhaps a measure of job dissatisfaction. Psychological abuse was related to having a stressful personal life. The Royal College of Nursing (RCN) (1996) identified having a controlling personality, poor attitude and low morale as aetiological factors in abuse.

Unconsciously, transference/countertransference issues will be important – the patient may represent parents or grandparents to the carers, or their projected selves in old age. Feelings of anger, hatred and fear that have not been worked through can be dangerous. Personal feelings of inferiority may be stimulated in identification with the patient. Sado-masochistic traits may come to the fore in the unequal power relationship; 'power corrupts' is an old story. Davenhill (1998) writes of primitive psychic processes in settings where staff work with patients with severe psychological disturbance. Whether painful and potentially destructive feelings are acted out or transformed by workers is central to the quality of interactions and care the patients or residents receive.
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Psychosocial

The microcosm of the ward or the residential home, unless there are positive forces working against it, will reflect the negative images of old age that we all carry in our conscious and unconscious minds (Evans, 1998; Garner & Ardern, 1998). To have youth seems to be everything. To be old is to be seen as a burden on the younger generation. Pillemer & Moore (1989) found that staff who have overtly negative attitudes towards elderly people are more likely to behave inappropriately towards them.

We have a fierce reluctance to examine the darker side of ourselves and our society, a reluctance to undermine our complacency. De Beauvoir (1970) in her treatise on old age moots the possibility of an innate drive to cull the aged to make room for the young. She gives an extensive ethnological and anthropological account of numerous cultures – mostly extinct, but some contemporary – that abuse, maltreat or even murder their elders in order to maintain sufficient resources for the young. Is this so different from working in the kind of environment that uses phrases like 'rising tide' of the elderly (Health Advisory Service (HAS), 1985), or 'burden on the tax payer'? Civilised society may be nothing more than a thin veneer of relative wealth covering baser instincts. Consider, for example, the resurgence of racism at times when unemployment levels are high.

Should this appear an extreme view, one might recollect a few years ago when a London hospital trust closed its accident and emergency department to people over the age of 70. The decision was quickly retracted after a public outcry. More recently, an accusation of involuntary euthanasia was levied against the National Health Service in general in its treatment of elderly people. It has been suggested that some hospitals have deprived their older patients of food and drink, and have withheld appropriate treatments (*Daily Telegraph*, December 1999). The Department of Health were quick to deny the existence of any policy of withholding treatment from elderly people, but Age Concern promised further investigations. The truth in these two cases, as often turns out, probably exists in some middle ground; and there may be issues here that are more pertinent to rationing. The health service already implements rationing to some extent. In the absence of limitless resources, decisions have to be made about who will benefit most from treatment, and which patients require urgent attention. Older people may be considered untreatable more often than younger people for a variety of reasons, some ageist, some valid. Therefore, although rationing and discrimination are two separate concepts, there is a grey area between them into which older patients will fall.

Working in the kind of social environment in which we are constantly reminded of the limited financial resources will both consciously and unconsciously affect our professional decision-making processes. Foulkes (1964), the founding father of group analysis, who was influenced not only by psychoanalysis, but also by the social theorist Norbert Elias, wrote of "the colossal forces of our society". He

suggested that these permeate us to the core, and therefore influence our day-today actions. In the face of battling with a profound lack of resources, National Health Service clinicians may unwittingly operate an ageist policy (*Lancet*, 1993) without explicitly rationing care. As new hospital buildings are commissioned, the elderly mentally ill often seem to be the group to remain in old, ill-designed, crumbling wards. Victor & Vetter (1986) have argued that this is also a gender issue. Females outnumber males in institutional settings; poverty and isolation affect more old women than old men.

Provision of day care placements and lodging are built on a Victorian model of charitable welfare, where the basic minimum is provided but with neither choice nor flexibility; couples can rarely continue to live together should one partner be suffering from dementia too severely to be cared for at home; day centres are offered with no consideration as to whether clients have anything more in common than advanced age. Slater & Eastman (1998) view this as an "explicit location of elder abuse within the social relations of later life".

Goodridge (1996) found a correlation between staff/patient conflict and abuse, particularly over issues of personal hygiene and the wish of patients to go outside. The RCN (1996) identified lack of support and working in isolation as important. Payne & Cikovic (1995), analysing abusive incidents in American nursing homes, found that only 25% of incidents were witnessed. In their study, male staff were more likely to abuse male patients, female staff to abuse female patients. This may be explained by a recrudescence of Oedipal conflicts or an identification with the patient and a desperate fear of one's own old age.

Terry (1998) links the infantilisation of older people that emphasises the split between staff and patients with the difficulty in *thinking* that occurs on long-stay wards. He sees both as connected to a dread of our own infantile feelings of dependency and in its most extreme an infantile dread of death, "the nameless dread of falling to pieces" (Bion, 1962).

Bell (1996) and Terry (1998) extend the concept of 'destructive narcissism' described by Rosenfeld (1971) to society generally. Human need and vulnerability are viewed as weakness and with mockery and hatred. Terry (1998) writes that older people in long-stay care represent the ultimate insult because they are reminders of an infantile dependency and decline into vulnerability and death.

Patient characteristics

Aitken & Griffin (1996) suggest that older people with mental or physical impairment are at greatest risk of abuse. They may be seen to offer staff few rewards in the sense of positive therapeutic achievement. Some surveys have revealed a high level of patient violence towards staff (Eastley *et al*, 1993). Aggressive patients are more likely to have aggression shown towards them (Pillemer & Moore, 1989). Patients cared for in the settings under consideration will present a variety of difficulties modulated or exaggerated by personality differences and brain damage. They may be irritating and repetitive, resistive to

care and aggressive, ungrateful and demanding or physically disgusting. To consciously ignore these descriptions, which all staff will recognise in some of their patients, is to increase the likelihood of unthinking mistreatment. In all situations of abuse, the role of the victim needs to be considered, and there may be collusive aspects to the abuse; however, whatever the provocation or invitation, staff are under an obligation to maintain professional boundaries and understanding.

Organisational factors

In Goffman's (1961) 'total institution', inmates are separated from social intercourse with the outside world, daily life is carried out by timetable (batch living), there is a basic distinction between managers and the managed, and the aims of the institution are more important than the aims of the individuals within it. Physical and psychological reminders of personal identity are stripped by restricting personal possessions, privacy and individual responsibility. Mobility is restricted. Although on the page this makes for bleak reading, everyone who works with older people, visiting wards and homes will recognise some of the above description. Different institutions will have different cultures, but on the whole the predominant culture is one of warehousing older citizens. Homes that do adequately care for someone physically rarely consider the emotional life of the patient.

Kitwood (1990), in writing of the "malignant social psychology" that surrounds patients with dementia, recognises that people often function at a worse level than that determined by the dementia alone because of the attitudes of the surrounding *carers*. Terry (1997), a psychologist working on a long-stay geriatric ward, writes of "deadly institutionalisation", by which he meant staff 'servicing' patients with regimens of tasks, the lack of contact between patients and the limited social and emotional engagement between patients and staff.

Caring for older dependent people is difficult, demanding and stressful work (Terry, 1997; Ardern *et al*, 1998). In the private sector, some staff are employed on very poor terms and conditions (Terry, 1998). Consciously and unconsciously, resentful and demoralised staff can displace their own feelings onto patients, whom it is easier and safer to attack than their managers or employers. The abuse of staff has a 'domino effect'. While consulting to a long-stay geriatric ward, it became clear to Roberts (1994) that quality of life for the patients was inextricably linked to the quality of life for the staff. In addition, this type of work has traditionally been of low status within the nursing profession, reflecting the position that the patients hold within society.

Staffing recruitment, retention, skills mix and training are crucial. An understaffed, undertrained unit will not be able to do imaginative work with residents. Employing very young staff will be cheaper, but they may have no knowledge, understanding or experience of people with difficulties in later life. However, staff who have worked in the same place and in the same way for

years may think they *know it all* and there is nothing they can learn (Pritchard, 1996). Destructive factions similar to those described as ‘anti-group’ by Nitsun (1996) may affect and split staff. In some units, an atmosphere develops in which staff who are critical of others or the regime are punished. They may be intimidated, ostracised or victimised. Group norms are powerful. In these circumstances, it takes a brave person to speak out.

Staff burn-out, characterised by physical, psychological and spiritual exhaustion, has been implicated by a number of authors (Pillemer & Moore, 1989; Eastman, 1994; UKCC, 1994) as a feature of environments where abuse occurs. The World Health Organization (1995) has described and reviewed ways to identify and prevent such burn-out.

Leadership plays a vital role in setting the culture (e.g. task-oriented or choiceoriented) and in giving meaning and value to the work that is done. Is the fastest worker commended, or the one who spends most time talking with residents? In Lee-Treweek’s review (1994), “workers felt resistance to the individual’s emotional needs was central to time-saving”. The poor manager may be weak and ineffectual or strong and *efficient*, with efficiency masking rigidity and an inability to listen. Senior staff may have an *ad hoc* reactive style, resulting in crisis management and an inability to see the whole picture. Management may fail to see a pattern of events that are treated as individual instances in isolation (London Borough of Enfield, 1993).

Often, work with residents is carried on without adequate supervision, trained staff in the office engaged in the all important ‘paperwork’ and untrained staff doing the ‘caring’ (Menzies-Lyth, 1999).

Much abuse is subtle. Managers and workers need at one and the same time to think broadly across the institution and about the minutiae of their individual interactions with patients and other staff. In training, the capacity to empathise should be encouraged. Dementia care mapping (Kitwood & Bredin, 1992), in which everything that happens to a patient in a defined period is minutely observed and detailed, is a useful exercise in this context.

Menzies-Lyth (1959), in her classic nursing study, described the hospital as a social defence system that represented an institutionalisation of primitive anxieties.

The ‘role’ of the nurse is equated with the ‘task’ of care, which is seen as keeping the patient alive, clean, fed, etc., to the neglect of the emotional needs of both the nurse and the patient.

The role of the doctor

Mistreatment of patients is not confined to nurses and care assistants who may sometimes be scapegoated. Individual doctors have been charged with the grossest of abuse of patients. However, in the institutions under consideration the role of the doctor in ill-treatment is more likely to be ignorance, unthinking,

prejudice and collusion. With regard to medical interventions, ill-considered ageist assumptions can lead to therapeutic nihilism; a recent Audit Commission (2000) report into mental health services for older people reports that only 20% of residents of homes are receiving antidepressants, although 40% are likely to be suffering from depression. Conversely, refusal to accept the defeat inferred from some prognoses may induce therapeutic mania and 'heroic treatments', which benefit no one. In homes, patients with dementia and some without are frequently prescribed psychotropic medication (McGrath & Jackson, 1996; Audit Commission, 2000). Staff, in collaboration, need to develop more imaginative ways of managing troubled and troublesome patients. It is not unknown that the patient/resident gets the sedative when staff feel overwhelmed by the problems presented to them. It is often easier to give a drug than to work on changing attitudes and altering the way staff deal with particular behaviours. Using a psychoanalytic paradigm, it is possible to understand the identification by the nursing staff with the helplessness of the patient. Nurses may in turn lodge their feelings of helplessness with the prescribing doctor, who is made to feel that something (anything) must be done.

Many doctors will echo Virginia Bottomley's remarks on Newsnight (BBC TV, 4 June 1991): "I don't frankly think that abuse of elderly is a major issue, thank goodness, in our society". If they do accept that it exists as a social phenomenon, it happens in *other units*, not where they work. The tragic history of the world is peopled by those who *did not see*, *did not know* and therefore did nothing. Doctors need and wish to get on with other staff, but taking everything one is told at face value may represent psychosocial *naïveté* and unwitting collusion.

The most critical variable in quality of care is the relationship between patients and staff, and it is here that the psychiatrist may be most helpful, although he or she may find it difficult being in the position of consulting to an institution while at the same time being a part of it. Much abuse is unthinking – most of the people referred to the UKCC following allegations of ill treatment do not even realise that what they are doing constitutes abuse (*Nursing Times*, 24 February 1999). Doctors can encourage and model self-criticism. They can overturn that misplaced political correctness that puts a taboo on saying anything negative about people. In spite of professional ideals, ordinary human feelings are inevitable (Main, 1957). Sharing the idea with colleagues that "Mr X. makes me feel frustrated and angry" is not the same as behaving angrily with Mr X. Saying

is not doing. Providing a forum for discussion and understanding of workrelated problems and feelings can prevent them being acted out and address the 'mindlessness' and 'detachment' (Terry, 1997) that may characterise much staff/patient interaction. Winnicott's seminal paper (1949), 'Hate in the countertransference', gives 'permission' to face unacceptable negative feelings about patients, rather than using the defences of denial and projection. The capacity to tolerate hate 'without doing anything about it' depends on being completely

aware of the hate. Staff need the freedom to recognise negative as well as positive feelings. At the same time, psychiatrists will be aware that too zealous an attempt to examine motives may fuel anxiety rather than understanding.

The paucity of literature on treatment of victims is noteworthy. It is perhaps indicative of difficulties in making objective measures of the medium- and longterm sequelae of ill-treatment, but may also be colluding in making the older person the object not the subject of abuse.

Within the hierarchy of the National Health Service, doctors are in a position to influence significantly the culture and atmosphere of the units where they treat patients. Since the inquiry into the death of Stephen Lawrence (McPherson, 1999) institutions are being invited to examine individual and collective racism. Old age psychiatrists have a responsibility to take the lead in prompting an examination of ageism and the capacity for abuse in the homes and wards where they work. "Patients must be able to trust doctors with their lives and wellbeing" (General Medical Council, 1995).

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Recognition of abuse

The literature contains little empirical data about the consequences of abuse on the victim. Clinical reports have documented the severe emotional distress experienced by mistreated older persons and their increased mortality rate. Some definitions of abuse, for example, that of the Law Commission (1995), have included notions of significant harm; this may be correct in considering when to intervene in a family, but thresholds need to be lower in an institutional setting. In addition, 'significant harm' may not be apparent except to the skilled clinician in a patient already suffering from a profound dementia. Baumhover & Beall (1996) note that the absence of concrete evidence should not be construed as absence of negative sequelae or emotional trauma. Depression, learned helplessness and alienation, post-traumatic stress disorder, guilt and denial have all been reported (Wolf, 1997).

Normal ageing, disease and mistreatment may coexist. Diagnosis may be confounded by skin that is fragile and bruises easily, weight loss and social withdrawal. Some patients are be able to complain about and describe what has happened to them. A patient with dementia may confound events from the past with current situations (both may be true).

Factors from Appendix II should raise suspicion of abuse and prompt a more thorough investigation (London Borough of Enfield, 1993; Pritchard, 1996; Bennett *et al*, 1997; Action on Elder Abuse, 1998).

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Recommendations

The introduction of national required minimum standards in long-term care (Department of Health, 1999) is to be welcomed, but could have usefully emphasised the necessity of attending to the emotional life of residents and the

potential for abuse.
Major inquiries into units where mistreatment has occurred have made similar remedial suggestions for the future; Bennett *et al* (1997) remind us that the means of detecting and preventing abuse are known. Perhaps the causes of abuse are so deep-rooted personally and socially, consciously and unconsciously, that apparently simple common-sense measures are not implemented – sharing lessons between and within organisations, exit interviews, open management, open visiting, advocacy schemes, identifying staff burn-out, individualised care plans and flexible care regimes and training to change perspective and practice. All staff employed to care for children are now subject to a police check. The Allit inquiry (Clothier, 1991) into the deaths of children in hospital recommended more stringent pre-employment health checks.
There is clearly scope to increase the powers of home inspection and registration teams, who should always arrive unannounced; visits could be extended over a few days incorporating a residential element, with members of the team having a particular brief to imagine themselves in the resident's place, having to live their lives day after day.
The Health Advisory Service (2000) undertook in 1998 an independent enquiry into the care of older people on acute wards in general hospitals. They comment: "the poor image and profiles of this age group and the skills of the people providing services for older people need to be tackled at every level of the health and social care system". This report will confine itself to recommendations for doctors in the prevention, detection and management of abuse of old people in continuing care settings.

Organisational

1. Set a tone that respects dignity, privacy, choice and control (Hayley *et al*, 1996).
2. Where possible, examine the care regime of the unit with the manager; it may be inherently abusive. Clarify grey areas, as not all staff are aware of which practices constitute abuse.
3. Work collaboratively with nursing and care staff while maintaining sufficient distance to permit judgement.
4. Visit units frequently and at irregular times; encourage other members of the team to do the same – this is not to *check up* on the staff but to decrease

isolation of the unit and increase the opportunities to discuss problems and successes.

Clinical

1. When abuse is suspected, this **must** be reported. The doctor's primary responsibility is to ensure the safety and well-being of the patient. Arrange for appropriate support for the victim.
2. In order that patients may be involved in their own care as much as possible, routinely assess and facilitate competence and decision-making

capacity.
3. Use psychotropics cautiously, review prescriptions regularly and initiate guidelines for the use of medication.
4. Use case reviews to model self-criticism and to voice countertransference issues.
5. Research into the management and care of victims of ill treatment.

Training

1. Under- and postgraduate medical training in care of the elderly could be improved in the following areas:
(a) recognition of non-accidental injury;
(b) management of the aggressive elderly patient;
(c) management of the *demanding* patient;
(d) management of staff/patient conflict;
(e) management of the patient no one likes;
(f) how to communicate with patients who have cognitive impairment;
(g) management of sexuality in continuing care settings;
(h) assessment of competence and decision-making capacity; and
(i) moral, ethical and legal issues in the care of the older patient.
2. Assist in the training of nursing/care staff in the above areas.
3. Ensure the provision of psychotherapy supervision for senior house officers and other staff, which will aid a better understanding of conscious and unconscious processes in patients and staff and of institutional and group dynamics.
4. Use contact with units as an opportunity for introducing new ideas to staff and for discussing wider issues in the care of older people so that the unit sees itself as part of a whole.

Sociocultural

1. Advocate on behalf of mentally ill patients whenever possible.
2. Generally encourage advance care planning by use of advance directives, etc., so that the patient's view is incorporated into decision-making.

Conclusion

There are many examples of good practice in residential and nursing homes and on long-stay National Health Service wards. Despite that, institutional abuse of older people is common, insidious and a serious indictment of the caring professions, including medicine. Aetiological factors are multiple, complex and deep-rooted, but individuals' responsibilities are clear (General Medical Council, 1995). Old age psychiatrists' daily work brings them into intimate contact with the difficulties inherent in caring for disabled and dependent older people and the ambivalent feelings this evokes; they are in a position to understand and influence the institutions with which they are in contact and have a duty so to do. Specific recommendations are made for doctors in the prevention, recognition

and management of abuse of old people in institutional care settings.
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References

Action on Elder Abuse (1998) *The Abuse of Older People in Hospital. Information for Workers*. London: AEA.

Aitken, L. & Griffin, G. (1996) *Gender Issues in Elder Abuse*. London: Sage.

Ardern, M., Garner, J. & Porter R. (1998) Curious bedfellows: psychoanalytic understanding and old age psychiatry. *Psychoanalytic Psychotherapy*, **12**, 47–56.

Audit Commission (2000) *Forget Me Not: Mental Health Services for Older People*. London: Audit Commission.

Baumhover, L. A. & Beall, S. C. (1996) *Abuse, Neglect and Exploitation of Older Persons: Strategies for Assessment and Intervention*. London: Jessica Kingsley.

Bell, D. (1996) Primitive mind of state. *Psychoanalytic Psychotherapy*, **101**, 45–57.

Bennett, G., Kingston, P. & Penhale, V. (1997) *The Dimensions of Elder Abuse: Prospectus for Practitioners*.

Basingstoke and London: Macmillan.

Biggs, S. (1996) Elder abuse and the policing of community care. *Generations Review*, **6**, 2–4.

Bion, W. R. (1962) A theory of thinking. Reprinted (1988) in *Melanie Klein Today*, vol. 1 (ed. E. Bott-Spillius), pp. 178–186. London: Routledge.

Brammer, A. & Biggs, S. (1998) Defining elder abuse. *Journal of Social Welfare and Family Law*, **20**, 285–304.

Camden & Islington Community Health Services NHS Trust (1999) *Beech House Enquiry.* London: Camden & Islington Community Health Services NHS Trust.

Clothier, C. (1991) *The Allitt Enquiry. Independent Enquiry Relating to the Death and Injuries on Children's*

Wards at Grantham and Kesteven General Hospital During the Period February to April 1991. London: HSMO.

Davenhill, R. (1998) No truce with the furies. *Journal of Social Work Practice*, **12**, 149–157.

De Beauvoir, S. (1970) *La Vieillesse* (*Old Age*; transl. 1977). London: Penguin.

Department of Health (1993) *No Longer Afraid: The Safeguard of Older People in Domestic Settings*. London: HMSO.

—— (1999) *Fit for the Future? National Required Standards for Residential and Nursing Homes for Older People. Consultation Document*. London: HMSO.

—— (2000) *No Secrets: The Protection of Vulnerable Adults*. London: Department of Health

Eastley, R. J., MacPherson, R., Richards, H., *et al* (1993) Assaults on professional carers of elderly people. *British Medical Journal*, **307**, 845.

Eastman, M. (1994) *Old Age Abuse, A New Perspective*. London: Chapman and Hall.

Evans, S. (1998) Beyond the mirror: a group analytic exploration of late life and depression. *Aging and Mental Health*, **2**, 94–99.

Foulkes, S. H. (1964) *Therapeutic Group Analysis*. London: George Allen and Unwin.

Garner, J. & Ardern, M. (1998) Reflections on old age. *Aging and Mental Health*, **2**, 92–93.

General Medical Council (1995) *Duties of a Doctor*. London: GMC.

Gibbs, J., Evans, M. & Rodway, S. (1987) *Report of the Enquiry into Nye Bevan Lodge, London Borough of*

Southwark. London: London Borough of Southwark.

Gilleard, C. (1974) Physical abuse in homes and hospitals. In *Old Age Abuse*. *A New Perspective* (ed. M. Eastman). London: Chapman and Hall.

Glendenning, S. (1997) The mistreatment and neglect of elderly people in residential centres: research outcomes in the mistreatment of elderly people. In *The Mistreatment of Elderly People*, 2nd edn (eds P. Decalmer & S. Glendenning). London: Sage.

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Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Reading:

Penguin.

Goodridge, D. (1996) Conflict and aggression as stressors in the work environment of nursing assistants: implications for institutional elder abuse. *Journal of Elder Abuse and Neglect*, **81**, 49–67.

Griffiths, D., Roberts, G. & Williams, J. (1997) Elder abuse and the law. In *The Mistreatment of Elderly People*, 2nd edn (eds P. Decalmer & S. Glendenning). London: Sage.
Health Advisory Service (HAS) (1985) *The Rising Tide*. London: HMSO.
—— (2000) *Not Because They Are Old: An Independent Enquiry into the Care of Older People on Acute Wards in General Hospitals*. London: HAS.
Hayley, D. C., Cassel, C. K., Snyder, L., *et al* (1996) Ethical and legal issues in nursing home care. *Archives of Internal Medicine*, **156**, 249–256.
Kingston, P. & Reay, A. (1996) Elder abuse and neglect. In *Handbook of the Clinical Psychology of Ageing* (ed. R. Woods), pp. 423–438. Chichester: John Wiley & Sons.
Kitwood, T. (1990) The dialectics of dementia: with particular reference to Alzheimer's disease. *Ageing in Society*, **10**, 177–196.
—— & Bredin, K. (1992) *Evaluating Dementia Care: The DCM Method*, 6th edn. Bradford: Bradford Dementia Research Group.
Lancet (1993) Do doctors short-change older people? *Lancet*, **342**, 1–2.
Law Commission (1995) *Mental Incapacity*. London: HSMO.
Lee-Treweek, G. (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review*, **4**, 2–4.
London Borough of Enfield (1993) *Notes of Guidance (Practice and Procedure). Abuse of Vulnerable Adults*.
London: London Borough of Enfield.
McPherson, W. (1999) *The Stephen Lawrence Enquiry*. London: HMSO.
Main, T. F. (1957) The ailment. *Medical Psychology*, **30**, 129–145.
McGrath, A. & Jackson, G. A. (1996) Survey of neuroleptic prescribing in residents of nursing homes in Glasgow. *British Medical Journal*, **312**, 611–612.
Menzies-Lyth, I. (1959) The functioning of social systems as a defence against anxiety. Reprinted (1988) in *Containing Anxiety in Institutions: Selected Essays*, vol. 1. London: Free Association Books.
—— (1999) Facing the crisis. *Psychoanalytic Psychotherapy*, **13**, 207–212.
Nitsun, M. (1996) *The Anti-Group: Destructive Forces in the Group and their Creative Potential*. London: Routledge.
Payne, B. & Cikovic, R. (1995) Empirical examination of the characteristics, consequences and causes of elder abuse in nursing homes. *Journal of Elder Abuse and Neglect*, **74**, 61–74.
Pillemer, K. & Moore, D. W. (1989) Abuse of patients in nursing homes: findings from a survey of staff. *Gerontologist*, **29**, 314–320.
Pritchard, J. (1996) *Working with Elder Abuse: A Training Manual for Home Care, Residential and Day Care Staff*. London: Jessica Kingsley.
Roberts, V. Z. (1994) Caring and uncaring in work with the elderly. In *The Unconscious at Work. Individual and Organisational Stress in Human Services* (eds A. Obholzer & V. Z. Roberts). London: Routledge.
Rosenfeld, H. (1971) A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism. *International Journal of Psychoanalysis*, **52**, 169–178.
Royal College of Nursing (1996) *Combating Abuse and Neglect of Older People*. London: RCN.
Slater, P. & Eastman, M. (1998) Elder abuse and social power: critical objectives. *Action on Elder Abuse Bulletin*, **32**.
Stevenson, O. (1999) *Elder Protection in Residential Care: What Can We Learn from Child Protection*. London: Department of Health.

Terry, P. (1997) *Counselling the Elderly and their Carers*. Basingstoke: Macmillan.
—— (1998) Who will care for older people? A case study of working with destructiveness and despair in long stay care. *Journal of Social Work Practice*, **12**, 209–216.
UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1994) *Professional Conduct. Occasional Report on the Standards of Nursing in Nursing Homes*. London: UKCC.
Victor, C. R. & Vetter, N. J. (1986) Poverty, disability and the use of service by the Elderly. *Social Services and Medicine*, **22**, 1087–1091.
Wardhaugh, J. & Wilding, P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy*, **37**, 4–31.
Winnicott, D. (1949) Hate in the countertransference. *International Journal of Psychoanalysis*, **30**, 69–74.

Wolf, R. S. (1997) Elder abuse and neglect: causes and consequences. *Journal of Geriatric Psychiatry*, **31**, 153–174.
World Health Organization (1995) How to prevent burn out. *International Nursing Review*, **425**, 35–45.

Appendix I

Physical abuse – some examples

- assaults that may or may not cause observable injury (punching, slapping, pinching, kicking, pushing or rough handling)
- bathing patients in water that is too hot or too cold
- force-feeding
- punishing by denying food, warmth and comfort
- use of physical restraint
- neglect of nutrition or hydration
- over-sedation
- not dressing or cleaning the incontinent patient
- ignoring painful or treatable conditions
- treating all medical conditions routinely without consideration of the individual
- an attitude of medical nihilism

Psychological abuse – some examples

- lack of personal information about a resident so they cannot be treated as an individual
- not acknowledging the patient as an individual
- bullying or threatening behaviour, intimidating or causing anxiety to patients
- humiliation, e.g. ‘telling patients off’
- verbal abuse, swearing and shouting
- teasing a patient who does not understand, or other forms of ridicule
- infantilisation
- lying to patients, even if it seems the easiest solution

Financial abuse – some examples

- taking anything that belongs to the older person
- not spending money from the person’s account on things that they could enjoy
- giving in to pressure from a relative to keep a person in hospital when more appropriate residential care would affect the former’s inheritance
- colluding with relatives to sign enduring power of attorney, wills, etc.
- extension of the enduring power of attorney to issues of treatment extends the scope for abuse

Sexual abuse

- Patients who are physically and mentally disabled need assistance with personal care. Staff perform intimate tasks with patients' bodies. Any sexualisation of this particular contact is abuse.
- Patients may invite physical contact unrelated to washing and dressing; hand-holding or an arm round someone may be comforting, but there must be boundaries.
- Recognising that a patient/resident is still a sexual being is not abusive; they may need a private space to meet with a partner or to masturbate.
- How to treat patients as gendered beings with sexual needs while maintaining appropriate boundaries may be a topic for training.

Social abuse – some examples

- impoverished physical environment
- lack of personal space and privacy
- lack of personal possessions
- any punitive treatment
- music and television for the tastes of the staff, not the residents
- running the unit for the convenience of the staff, not the residents
- lack of choice: food, clothes, timetable, general practitioner, etc.
- lack of activities/stimulation
- admitting friends to different units
- lack of flexibility in accommodation, so that partners are separated
- isolation – confining patients to their room
- stereotyping older people
- labelling a patient as 'bad'
- blanket policies
- ignoring the dignity of the patient

Appendix II

Physical indications of abuse

- unexplained falls and injuries
- multiple bruising not consistent with a fall
- old and new bruises at the same time
- finger marks
- bruising on inner thighs, blood on underwear and sexually transmitted disease/frequent infections/genital or urinary irritation
- patient trying to hide part of his or her body on examination
- accidents in unexpected places or at unexpected times
- burns
- signs of neglect: unattended incontinence and malnutrition/dehydration
- inappropriate administration of medication or under-use of medication

Behavioural indications of abuse

- marked change in behaviour

- cowering
- fearfulness with particular staff
- unusual clinging
- seeking attention/protection
- making great efforts to please
- appearing anxious, agitated or withdrawn
- unusual weeping or sobbing
- unexplained paranoia
- unexplained angry outbursts or aggression
- low self-esteem
- change in appetite
- sudden onset of confusion
- depression
- change in a patients behaviour or attitude to sex

Institutional indications of abuse

- isolation of residents
- problems over access to residents
- visitors discouraged
- a 'closed' and isolated environment

- a run-down environment
- too much staff autonomy
- high staff absenteeism/sickness
- 'anti-group' behaviour, scapegoating
- paranoia among staff
- rigid attention to routine
- lack of individual care plans
- poor standards of cleanliness

Indications of financial exploitation

- missing or controlled belongings, money, pension book, etc.
- inability of residents to buy essential items
- misappropriation of residents personal allowances
- particular interest by a member of staff in a patient's assets/will
- 'gifts' to a member of staff

Elder Abuse

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Introduction

Background: Over the past 35 years, tremendous strides have been made in identifying and increasing awareness about patterns of abusive relationships. Child abuse and domestic violence have received significantly more recognition than elder abuse and continue to receive more attention in both public and medical domains, although abuse clearly occurs in persons of all ages.

People are living longer with current medical advances and healthier lifestyles. In 1990, it was estimated that older persons comprised just 13% of the US population. By the year 2050, this proportion is projected to increase to 25%; the number of people older than 85 years is expected to double.

As a result, the number of elder abuse cases will increase, and the impact of elder abuse as a public health issue will grow. Aging adults involved in abusive relationships often visit the ED for treatment. Emergency physicians are well positioned to help these victims.

The terminology used to describe elder abuse is not consistent. Terms vary among researchers, and usage is not consistent in the laws of different states. Even the age at which a person is considered elderly, usually 60 or 65 years, is debated. Seven categories of elder abuse have been described by the National Center on Elder Abuse (NCEA), formerly the National Aging Resource Center on Elder Abuse. Categories include the following:

- Physical abuse is defined as any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication.
- Psychological or emotional abuse is conduct that causes mental anguish. Examples include threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute abuse.
- Financial abuse is misuse of an elderly person's money or assets for personal gain. Acts such as stealing (eg, money, social security checks, possessions) or coercion (eg, changing a will, assuming power of attorney) constitute financial abuse.
- Neglect is the failure of a caretaker to provide for the patient's basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or

dentures, preventive health care, safety precautions, or hygiene.
Emotional neglect includes failure to provide social stimulation (eg, leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.
Sexual abuse is defined as nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.
Self-neglect is behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient's right of autonomy and the physician's oath of beneficence.
The miscellaneous category includes all other types of abuse, including violation of personal rights (eg, failing to respect the aging person's dignity and autonomy), medical abuse, and abandonment.

Frequency:

- **In the US:** Due to the inconsistencies in definitions of elder abuse, obtaining accurate information on elder abuse incidence is difficult. A 1991 report from the House Select Committee on Aging suggests that 1-2 million adults older than 60 years are abused each year. Other studies suggest that 3-10% of elders are abused or neglected.
  Many factors (eg, fear, shame, guilt, ignorance) play a role in the likely underestimation of the number of abused elders. In addition, many studies routinely exclude certain populations (eg, persons possibly unable to respond to a survey, speakers of languages other than English, persons with mental illness), further complicating accurate tallies of the number of older persons who are abused.

Race: Elder abuse occurs among members of all racial, socioeconomic, and religious backgrounds. The NCEA found the following racial and ethnic distribution among older persons who had been abused:

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

Sex: Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in women typically is greater than in men. Numerous studies, however, have found no differences based on sex.

Age: By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

Clinically

History: The American Medical Association recommends that doctors routinely ask geriatric patients about abuse, even if signs are absent. Keeping questions direct and simple and asking in a nonjudgmental or nonthreatening manner increases the likelihood that patients will respond candidly. The patient and the caregiver should be interviewed together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate, objective documentation of the interview is essential. The following questions can be used to elicit information about elder abuse.

- Physical abuse
    - Are you afraid of anyone at home?
    - Have you been struck, slapped, or kicked?
    - Have you been tied down or locked in a room?
    - Have you been force-fed?
- Psychological abuse
    - Do you ever feel alone?
    - Have you been threatened with punishment, deprivation, or institutionalization?
    - Have you received "the silent treatment"?
    - Do you receive routine news or information?
    - What happens when you and your caregiver disagree?
- Sexual abuse: Has anyone touched you in a sexual way without permission?
- Neglect
    - Do you lack items such as eyeglasses, hearing aids, or false teeth?
    - Have you been left alone for long periods?
    - Is your home safe?
    - Has anyone failed to help you care for yourself when you needed assistance?
- Financial abuse
    - Is money being stolen from you or used inappropriately?
    - Have you been forced to sign a power of attorney, will, or another document against your wishes?
    - Have you been forced to make purchases against your wishes?
    - Does your caregiver depend on you for financial support?
- Follow-up questions (if abuse is identified)
    - How long has the abuse been occurring?
    - Is it an isolated incident?
    - Why do you think this happens?
    - When do you think the next episode will occur?
    - Is the abuser present in the ED?
    - Is it safe for you to return home?
    - What would you like to see happen?
- Have you ever received help for this problem before?

Physical: As with other abusive relationships, elder abuse rarely resolves itself and probably will escalate over time. Signs of abuse may be blatant or subtle. A study by Lachs et al failed to show a specific injury type or pattern common to

elderly persons who had been abused; therefore, consider abuse in the differential diagnosis of every elderly person entering the ED. A number of clinical findings and observations make elder abuse a strong possibility, including the following:

- Several injuries in various stages of evolution
- Unexplained injuries
- Delay in seeking treatment
- Injuries inconsistent with history
- Contradictory explanations given by the patient and caregiver
- Laboratory findings indicating underdosage or overdosage of medications
- Bruises, welts, lacerations, rope marks, burns
- Venereal disease or genital infections
- Dehydration, malnutrition, decubitus ulcers, poor hygiene
- Signs of withdrawal, depression, agitation, or infantile behavior

Causes: Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved. Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, transgenerational violence, and psychopathology in the abuser.

- Physical and mental impairment of the patient
    - Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
    - Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.
- Caregiver stress
    - This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
    - The effect of stress factors (eg, alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons' violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers’ expressions of anger or antagonism toward the elderly person, resulting in violence.
    - This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.
- Transgenerational violence: This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.
- Psychopathology in the abuser: This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia, and other conditions

can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for elderly relatives because they are the individuals typically at home due to lack of employment.
- Other risk factors in abuse are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

Differentials

Other Problems to be Considered:
Dehydration
Gait disturbances
Pathologic fractures

Work Up

Lab Studies:
- Look for evidence of infection, dehydration, electrolyte abnormalities, malnutrition, improper medication administration, and substance abuse in patients who have been abused.
    - CBC
    - Chem-7
    - Urinalysis
    - Calcium, magnesium, phosphorus
    - Serum levels of relevant medications
    - Urine drug screen
    - Ethanol level

Imaging Studies:
- X-rays of relevant body parts - To detect fractures (unusual or pathologic)
- Head CT scan - To detect intracranial bleeding as a result of abuse or to detect a possible explanation for injuries (eg, hydrocephalus causing ataxia leading to falls)

Treatment

Emergency Department Care: Many factors are involved in the management of older persons who have been abused, including immediate care, long-term assessment and care, education, and prevention. Intervention can be a lengthy process, especially in a busy ED. Many hospitals have developed multidisciplinary teams (ie, social workers, physicians, nurses, administrators) to help in these situations. The ultimate goal is to provide the aging adult with a more fulfilling and enjoyable life.

- Immediate care focuses on treating the physical manifestations of abuse and assuring the safety of the patient. This may include the following:
    - Admitting the patient to the hospital
    - Obtaining a court protective order
    - Placing the patient in a safe home
    - Permitting return home if the patient is competent and refuses intervention

Consultations:

- Psychiatry consultation - For patients who are demented, depressed, disoriented, or incompetent
- Geriatrics consultation - For specialized care of the geriatric patient
- Neurology or neurosurgical consultation - For patients with focal neurological findings, or intracerebral bleeding
- Orthopedics consultation - For patients with fractures

Medication

No specific medication is used to treat elder abuse. Avoid anxiolytics and hypnotics because they make patients less able to defend themselves against acts of abuse.

Follow Up

Further Outpatient Care:

- Long-term assessment and care vary with the needs of the patient. Assessment usually involves a visit to the home to evaluate the patient's functional status, living environment, and the condition of the caregiver. The services needed to optimize the care of the patient can be determined only after a home visit.
- Stress to competent patients who refuse help that abuse rarely resolves—it usually escalates. Inform patients that a number of agencies can provide help; provide phone numbers and addresses of these agencies. Develop safety and follow-up plans before the patient leaves the ED.

Misc

Medical/Legal Pitfalls:

- Report all cases of suspected elder abuse to Adult Protective Services. Practically every state has a law mandating that physicians report elder mistreatment, and many have penalties for failing to report. Forty-three states mandate reporting of suspected cases of elder abuse. Some statutes require that licensed professionals who have not fulfilled their obligations to report elder abuse can be reported to the appropriate licensing authority.

- Mandatory reporting of elder abuse in competent patients is a controversial topic. A mandate to report domestic violence is seen by some as disempowering the abused individual, violating the right of autonomy. Therefore, reporting is not mandated in domestic violence cases.
    - Many use the same logic that mandatory reporting of abuse of mentally competent victims of elder abuse disempowers the abused individual.
    - The laws created for elder abuse were based upon child abuse laws; therefore, the inability of patients to make decisions in their own best interests was presumed. The laws are weak on matters such as financial abuse, since children generally have no money to exploit.
- While the laws are not perfect, a diagnosis of elder abuse, in fact, is reportable.

Special Concerns:

- Barriers to recognizing and reporting elder abuse also must be addressed. The lack of uniform definitions has been a major obstacle. Conceptual problems in defining elder abuse have hampered clinical, educational, and research efforts.
- Various factors serve as barriers to reporting elder abuse (eg, lack of knowledge, denial, ageism, fear of making the situation worse, desire to maintain family relationships, fear of ending up in court, lack of belief that the situation will improve). The key to eradicating these barriers is education that increases both public and professional awareness.
- Increasing awareness is considered instrumental in the prevention of elder abuse. Services for seniors, such as meals on wheels, home health care, homemaker, and chore services, are thought to aid in abuse prevention, although preventing elder abuse needs further study.

References

- Allison EJ, Ellis PC, Wilson SE: Elder abuse and neglect: the emergency medicine perspective. Eur J Emerg Med 1998 Sep; 5(3): 355-63[Medline].
- American College of Emergency Physicians: Management of Elder Abuse and Neglect. Policy Statement. Ann Emerg Med Jan 1998; 31(1): 149-150 [Medline].
- American Medical Association: Diagnostic Treatment Guidelines on Elder Abuse and Neglect. Chicago, IL: American Medical Association; 1992; 4-37.
- Birrer R, Singh U, Kumar DN: Disability and dementia in the emergency department. Emerg Med Clin North Am 1999 May; 17(2): 505-17, xiii [Medline].
- Clarke ME, Pierson W: Management of elder abuse in the emergency department. Emerg Med Clin North Am 1999 Aug; 17(3): 631-44, vi [Medline].

- Jones JS, Holstege C, Holstege H: Elder Abuse and Neglect: Understanding the Causes and Potential Risk Factors. Am J Emerg Med 1997; 15(6): 579-583[Medline].
- Jones JS, Veenstra TR, Seamon JP, Krohmer J: Elder Mistreatment: National Survey of Emergency Physicians. Ann Emerg Med 1997; 30(4): 473-479[Medline].
- Kleinschmidt KC: Elder abuse: a review. Ann Emerg Med 1997 Oct; 30(4): 463-72[Medline].
- Kruger RM, Moon CH: Can you spot the signs of elder mistreatment? Postgrad Med 1999 Aug; 106(2): 169-73, 177-8, 183[Medline].
- Lachs MS, Williams CS, O'Brien S, et al: ED Use by Older Victims of Family Violence. Ann Emerg Med 1997; 30(4): 448-454[Medline].
- Lachs MS, Pillemer K: Abuse and neglect of elderly persons [see comments]. N Engl J Med 1995 Feb 16; 332(7): 437-43[Medline].
- McDonald AJ, Abrahams ST: Social emergencies in the elderly. Emerg Med Clin North Am 1990 May; 8(2): 443-59[Medline].
- Paris BE, Meier DE, Goldstein T, et al: Elder abuse and neglect: how to recognize warning signs and intervene. Geriatrics 1995 Apr; 50(4): 47-51 [Medline].
- Rosenblatt DE, Cho K, Durance PW: Reporting Mistreatment of Older Adults: The Role of Physicians. J Am Geriatr Soc 1996; 44: 65-70 [Medline].
- Tintinalli JE, Ruiz E, Krome RL: Emergency Medicine: A Comprehensive Study Guide. McGraw Hill Text; 1996: 1377-78.

From website: National Center on Elder Abuse (USA)(www.elderabusecenter.org)

The Basics

Major Types of Elder Abuse

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Physical Abuse

?Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

Signs and symptoms of physical abuse include but are not limited to:

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- bruises, black eyes, welts, lacerations, and rope marks;
- bone fractures, broken bones, and skull fractures;
- open wounds, cuts, punctures, untreated injuries in various stages of healing;
- sprains, dislocations, and internal injuries/bleeding;
- broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained;
- laboratory findings of medication overdose or under utilization of prescribed drugs;
- an elder's report of being hit, slapped, kicked, or mistreated;
- an elder's sudden change in behavior; and
- the caregiver's refusal to allow visitors to see an elder alone.

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Sexual Abuse

Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Signs and symptoms of sexual abuse include but are not limited to:

- bruises around the breasts or genital area;
- unexplained venereal disease or genital infections;
- unexplained vaginal or anal bleeding;
- torn, stained, or bloody underclothing; and
- an elder's report of being sexually assaulted or raped.

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Emotional or Psychological Abuse

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

Signs and symptoms of emotional/psychological abuse include but are not limited to:

- being emotionally upset or agitated;

- being extremely withdrawn and non communicative or non responsive;
- unusual behavior usually attributed to dementia (e.g., sucking, biting, rocking); and
- an elder's report of being verbally or emotionally mistreated.

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?**Neglect**

Neglect is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.

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Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

Signs and symptoms of neglect include but are not limited to:

- dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- unattended or untreated health problems;
- hazardous or unsafe living condition/arrangements (e.g., improper wiring, no heat, or no running water);
- unsanitary and unclean living conditions (e.g. dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing); and
- an elder's report of being mistreated.

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Abandonment

Abandonment is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Signs and symptoms of abandonment include but are not limited to:

- the desertion of an elder at a hospital, a nursing facility, or other similar institution;
- the desertion of an elder at a shopping center or other public location; and
- an elder's own report of being abandoned.

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Financial or Material Exploitation

Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Signs and symptoms of financial or material exploitation include but are not limited to:

- sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the elder;
- the inclusion of additional names on an elder's bank signature card;
- unauthorized withdrawal of the elder's funds using the elder's ATM card;
- abrupt changes in a will or other financial documents;
- unexplained disappearance of funds or valuable possessions;
- substandard care being provided or bills unpaid despite the availability of adequate financial resources;

- discovery of an elder's signature being forged for financial transactions or for the titles of his/her possessions;
- sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions;
- unexplained sudden transfer of assets to a family member or someone outside the family;
- the provision of services that are not necessary; and
- an elder's report of financial exploitation.

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Self-neglect

Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

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 as a matter of personal choice.

Signs and symptoms of self-neglect include but are not limited to:

- dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene;
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no indoor plumbing, no heat, no running water);
- unsanitary or unclean living quarters (e.g., animal/insect infestation, no functioning toilet, fecal/urine smell);
- inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g., eyeglasses, hearing aids, dentures); and
- grossly inadequate housing or homelessness.

Elder Abuse/Mistreatment Defined

Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes.

Definitions in state law vary considerably from state to state in terms of what constitutes abuse, neglect, or exploitation of the elderly. Researchers also have used varying definitions to describe and study the problem.

Broadly defined, however, there are three basic categories of elder abuse:

- Domestic elder abuse
- Institutional elder abuse
- Self-neglect or self-abuse

While state definitions may vary, in most states, definitions of elder abuse generally fall within these three categories.

Domestic elder abuse generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver), that occur in the elder’s home, or in the home of a caregiver.

Institutional abuse, on the other hand, generally refers to any of the above-mentioned forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g., paid caregivers, staff, professionals).

Definitions and legal terms vary from state to state in regards to the types of domestic elder abuse that NCEA recognizes, as well as their signs and symptoms.

Risk Factors for Elder Abuse

Elder abuse, like other types of domestic violence, is extremely complex. Generally a combination of psychological, social, and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of elder maltreatment.

Although the factors listed below cannot explain all types of elder maltreatment, because it is likely that different types (as well as each single incident) involve different casual factors, they are some of the risk factors researchers say seem to be related to elder abuse.

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Domestic Violence Grown Old

It is important to acknowledge that spouses make up a large percentage of elder abusers, and that a substantial proportion of these cases are domestic violence grown old: partnerships in which one member of a couple has traditionally tried to exert power and control over the other through emotional abuse, physical violence and threats, isolation, and other tactics.

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Personal Problems of Abusers

Particularly in the case of adult children, abusers often are dependent on their victims for financial assistance, housing, and other forms of support. Oftentimes they need this support because of personal problems, such as mental illness, alcohol or drug abuse, or other dysfunctional personality characteristics.

The risk of elder abuse seems to be particularly high when these adult children live with the elder.

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Living with Others and Isolation

Both living with someone else and being socially isolated have been associated with higher elder abuse rates. These seemingly contradictory findings may turn out to be related in that abusers who live with the elder have more opportunity to abuse and yet may be isolated from the larger community themselves or may seek to isolate the elders from others so that the abuse is not discovered. Further research needs to be done to explore the relationship between these factors.

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Other Theories

Many other theories about elder abuse have been developed. Few, unfortunately, have been tested adequately enough to definitively say whether they raise the risk of elder abuse or not. It is possible each of the following theories will ultimately be shown to account for a small percentage of elder abuse cases.

- **Caregiver stress**. This commonly-stated theory holds that well-intentioned caregivers are so overwhelmed by the burden of caring for dependent elders that they end up losing it and striking out, neglecting, or otherwise harming the elder. Much of the small amount of research that has been done has shown that few cases fit this model.
- **Personal characteristics of the elder**. Theories that fall under this umbrella hold that dementia, disruptive behaviors, problematic personality traits, and significant needs for assistance may all

raise an elder's risk of being abused. Research on these possibilities has produced contradictory or unclear conclusions.

- **Cycle of violence**. Some theorists hold that domestic violence is a learned problem-solving behavior transmitted from one generation to the next. This theory seems well established in cases of domestic violence and child abuse, but no research to date has shown that it is a cause of elder abuse.

Who Are the Abusers?

It has been estimated that roughly two-thirds of all elder abuse perpetrators are family members, most often the victim's adult child or spouse. Research has shown that the abusers in many instances are financially dependent on the elder's resources and have problems related to alcohol and drugs.

Is Elder Abuse a Crime?

Most physical, sexual, and financial/material abuses are considered crimes in all states insofar as these acts violate statutes prohibiting crimes such as assault, battery, rape, theft, etc. In addition, depending on the perpetrators' conduct and intent, and the consequences for the victim, certain emotional abuse and neglect cases are subject to criminal prosecution.

State criminal statutes, adult protective laws, and federal statutes such as Medicare define and establish penalties for abuse, neglect, and exploitation of vulnerable adults. Prosecution of perpetrators is rare, however, and may be hampered by several factors including victims' fear of retaliation, hesitancy to prosecute family members, or lack of capacity to describe the crime or perpetrator.

While there has been some increase in cases prosecuted (particularly in the area of nursing home abuse largely due to aggressiveness of Medicaid Fraud Units), justice for elder abuse victims requires continued specialized training for police officers and other first responders, district attorneys, victim/witness professionals, lawyers, and the courts.

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Recent Developments

Efforts are underway by the criminal justice system to improve response to elder abuse. Here in brief are some recent developments:

- State Attorney General Offices and District Attorneys are setting up **specialized elder abuse investigation and prosecution units**.
- Communities are creating **multidisciplinary teams (MDTs or M-Teams)** composed of professionals from law enforcement, ombudsman, health, and adult protective services to collaborate on elder abuse cases.
- **Fatality (forensic) review teams** are being created to identify and respond to suspected cases of abuse.
- **Fiduciary abuse specialist teams (FASTs)** involving accountants, FBI, insurance claims detectives, and other specialists are playing an increasing important role in pursuing financial abuse cases.