Elder Abuse and Neglect: Appearances Can Be Deceptive

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The number of persons affected by elder mistreatment and self-neglect is growing—with consequent increases in morbidity and premature mortality.

Each year many older adults experience abuse, neglect, and exploitation by non-strangers who are expected to safeguard them and protect their interests. Self-neglect, where the elderly person has no effective caregivers, is also a commonly reported condition.¹ The number of persons affected by elder mistreatment and self-neglect is growing, with consequent increases in morbidity and premature mortality.²

Because elder mistreatment and self-neglect often occur in domestic settings, the chances of detection are limited.³ Unlike abused children who have more frequent exposure to individuals outside of their homes, older adults may not see anyone other than their abusive/neglectful caregiver until they visit a physician or emergency department. Self-neglecters may have even less contact with people. For these reasons, it is important that surveillance for elder mistreatment and self-neglect is conducted with each clinical encounter.

The most frequently reported form of elder mistreatment is self-neglect. The following Case Vignette illustrates how misleading the patient interview can be in a clinical environment when the patient does not appreciate his or her circumstances. Elderly patients may have neither sufficient appreciation of their circumstances nor the ability to make decisions about their living arrangements. Moreover, they often lack the ability to take reasonable steps to improve their situation.

CASE VIGNETTE

Mr X is a divorced 75-year-old who lives alone. He has been sent to an outpatient clinic for an evaluation by Adult Protective Services (APS). Although thin, he is well-groomed and clean; he sits in a wheelchair. He is pleasant with good eye contact, talkative, and engaging. He reports that he had been hospitalized but recovered and was discharged to go home. He has a history of multiple sclerosis, which affects his hands, making it hard to write; he has no other medical problems. He explains that although he is in a wheelchair, he is able to walk well without the wheelchair and is able to get about in his home without a problem. He indicates that he has no problems with daily living activities (eg, bathing, grooming, banking, transportation) and is able to take care of himself. He explains that although he is in a wheelchair, he is able to walk well without the wheelchair and is able to get about in his home without a problem. He indicates that he has no problems with daily living activities (eg, bathing, grooming, banking, transportation) and is able to take care of himself. Although he does well on his mental status exam, he refuses to do any writing or drawing tasks, saying that writing is difficult for him. He is not delirious, and he does not exhibit abnormality of thought or memory. On physical examination, it is noted that his legs are atrophic. Asked to walk, he earnestly tries to follow instructions, apparently thinking that he can get up, but he is unable to lift himself out of the wheelchair.

The APS worker provides more information: Mr X has a history of falling and being unable to get up; there were times when his utilities were cut off; he is often without food; and his home is cluttered and filthy. He has also had episodes of confusion.
Elder mistreatment and neglect

Elder mistreatment occurs when a caregiver or person in a trust relationship with an elderly person engages in actions or omissions that cause harm or discomfort; caregiver neglect is the omission of needed care; financial exploitation is the misappropriation of the elderly person's resources. Types of elder abuse include physical abuse, emotional abuse, sexual abuse, and abandonment.1 The most recent US national elder mistreatment prevalence study reported that approximately 11% of cognitively intact older adults reported at least 1 form of elder mistreatment in the previous 12 months.4 This number is likely an underestimate because many cases go unreported or undetected and abuse is more common among cognitively impaired older adults who may be unable to report the incident.5

Elder self-neglect

Elder self-neglect is defined as the inability of an older adult to arrange for what he needs for safe and independent living. It is the most frequent situation reported to APS nationwide and in some areas accounts for approximately 70% of the referrals.6 Elder self-neglecters are often found living alone and in squalor, with untreated or poorly managed medical conditions, functional impairments, and little social support.7,9 Study findings indicate that elder abuse is associated with increased risk of mortality. Participants who were referred to APS for mistreatment and self-neglect had poorer survival.10,11 The referred persons are often suffering from poor nutrition and unmanaged medical problems, unsafe living conditions, depletion of irreplaceable resources, and other circumstances that result in morbidity and loss of independence. Often elderly persons have less reserves physically, psychologically, cognitively, socially, and financially, thus the impact of elder mistreatment and self-neglect is amplified.5,7

Screening, risk factors, and clinical manifestations

Since elder mistreatment and self-neglect have such a large negative impact, it is the ethical responsibility of the clinician to be alert for and attempt to screen for these conditions.12 The AMA and other groups advise screening of elders for abuse in all practice settings.13,14 Screening starts with being alert for risk factors and the clinical manifestations of elder mistreatment and self-neglect. Risk factors for these conditions include isolation, unfavorable caregiver characteristics (drug use or mental illness), cognitive impairment, and mental illness. Cognitive impairment due to a progressive dementia or stroke is a frequent cause of vulnerability to elder mistreatment and self-neglect. Depression, schizophrenia, and psychosis involving delusions may also render the patient vulnerable by preventing him from appreciating his true circumstances. Signs of elder mistreatment and self-neglect may be poor hygiene; lack of medical adherence; poor living conditions; dehydration; demonstrated fear of caregivers; or poorly explained injuries, such as bruising and scarring. Pressure ulcers and malnutrition may be signs of elder abuse or neglect and call for inquiry. Keep in mind, however, that these signs may not always indicate that the patient is in a state of elder mistreatment or self-neglect. There may be other explanations, and the clinician should be in the best position to distinguish illness or normal aging from abuse or neglect. Non-physical signs of elder mistreatment include depression, thoughts of suicide, avoidant behavior, anxiety, and fear.

The patient may have been cleaned up by a caregiver or hospital employee before the physician sees him. This is illustrated in the case of Mr X—the condition of the patient in the clinical setting may not reflect reality. If there is suspicion of abuse/neglect, the patient should be thoroughly examined to look for the stigmata of abuse that may be hidden by clothes. If injuries are found, these should be photographed to preserve the evidence. Talk privately with the patient (away from potential abusers)—ask about his family and living arrangements, and ask if he is being abused, neglected, or exploited. Unfortunately, many abused, neglected, or self-neglecting elderly patients have cognitive problems that prevent them from giving reliable accounts of their circumstances. Brief screening instruments may also be of value. The Table provides an overview of several tools that can be used during brief clinical assessments. These screening tools range from 5 to 12 questions with varying reliability and validity. The majority of the assessments include self-report questions regarding current or past physical abuse, emotional abuse, and financial exploitation. Positive screens should raise the suspicion for abuse or potential self-neglect.

The case of Mr X illustrates problems with the evaluation of patients in the usual clinical situations. The clinician often has unreliable reports from impaired patients and a lack of reliable information to test for validity. A patient can do well on cognitive screening tests and yet have a profound lack of
insight and appreciation for his circumstances. There may be abhorrent and perhaps abusive situations that the patient is unable to talk about that may not be evident in the usual clinical setting.

It is not unusual for an articulate yet incapable self-neglecter to convince a physician that there is nothing wrong with his ability to live independently without supervision. It is also not unusual for a neglectful family member to convince a physician that there is no neglect or abuse happening in the home. Checking with independent sources (if available) that what the patient and/or caregiver is saying is true can be valuable in confirming suspicions of abuse or neglect. A home safety evaluation from a home health company can help the clinician get a more complete picture. The best information regarding the true situation may be from APS—they will investigate the home environment and will assess how well the patient is being cared for or whether the patient is able to safely live on his own.

**Interventions**

If, after doing a careful assessment of the patient and documenting your findings, elder mistreatment or self-neglect is suspected, information regarding legal and community resources and ongoing support should be offered. However, the most important intervention is to report the suspicion. The clinician should make a report to APS in the jurisdiction if the patient is living in the community. If the patient lives in a facility (nursing home or personal care home), a report should be made to the agency that regulates that type of facility in the jurisdiction. These agencies are experienced in evaluating cases. They have the resources to interview family members and neighbors, visit the home environment of the patient, get financial records, and otherwise investigate more completely the patient’s home circumstances. If the clinician’s evaluation raises suspicion that the elder mistreatment amounts to a crime and the patient is in danger of additional harm, it is advisable to report the facts supporting the suspicions to the police as well. APS staff will report what they think are crimes to the police, but earlier reporting by the clinician may help the police prevent further harm to the patient.

**Barriers to reporting**

Some clinicians are reluctant to report a suspicion of mistreatment. They may mistakenly feel that reporting is punitive. The point of reporting is to give the specialized social services agency a chance to stop the harm being done to the elderly person. APS is mandated to use the least restrictive alternative needed to stop the harm, and the agency has more than enough to do, so it will not interfere more than is absolutely necessary. Clinicians may feel that they have to have permission to report; however, in all but 6 states, reporting is specifically required by law regardless of the desires of the patient or family. The clinician may fear civil or criminal liability for reporting if his suspicions are not correct. However, most US jurisdictions specifically protect the good-faith reporter even if the mistreatment is not substantiated. Reporting can also be done anonymously to APS so that the relationship of the clinician to the family or patient is not disrupted. If the clinician wants to notify the patient or family, he can explain that a social services agency is charged with assisting people who need help, and the agency does not have a police or prosecutorial function.

**Summary**

Elder abuse, neglect, financial exploitation, and self-neglect are growing problems worldwide. They cause great hardship and suffering for many of the elderly. Clinicians have an obligation to be alert for these problems and intervene by reporting reasonable suspicions to the appropriate government agencies. In the rushed clinical environment, it is easy to miss the patient who desperately needs this help. It often takes help from reliable third parties, such as APS, to gather the information needed to fully appreciate the challenges faced by elderly patients.
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