Elder Abuse and Neglect
Definitions, Epidemiology, and Approaches to Emergency Department Screening

Michael C. Bond, MD*, Kenneth H. Butler, DO

KEYWORDS
- Elder abuse • Neglect • Geriatrics • Abuse

KEY POINTS
- Elder abuse and neglect is estimated to affect approximately 700,000 to 1.2 million elderly people a year with an estimated annual cost of tens of billions of dollars.1,2
- Elder abuse can take many forms (physical, neglect, financial, and so forth), the perpetrator is most commonly a family member, and elders that are maltreated are 3.1 times more likely to die in the next 3 years.3–5
- Despite the large population at risk, its significant morbidity and mortality, and substantial cost to society, elder abuse continues to be underrecognized and underreported. In one study, physicians reported only 1.4% of the abuse cases referred to adult protective services.6

_Every person…deserves to be treated with respect and with caring. Everyone, no matter how young or old, deserves to be safe from harm by those who live with them, care for them, or come in day-to-day contact with them._
—American Psychological Association3

INTRODUCTION

According to the US Census Bureau’s national population projections, the structure of the United States population is aging steadily.1–6 The first among the baby boomer generation reached retirement age in 2011, and the last will hit retirement age in 2029. Members of this generation currently account for 25% of the total population in the United States.7 The elderly population has become more visible, more active, and more independent than ever before. Because of advances in health care, they

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are living longer. But as this population grows, so do the hidden problems of elder abuse, exploitation, and neglect.

Research suggests that 700,000 to 1.2 million elderly people (ie, 4% of all adults older than 65) are subjected to mistreatment in the United States and that there are 450,000 new cases annually.2 Sadly, this statistic is an inaccurate underestimation, because for every case of elder abuse and neglect that is reported to authorities, as many as 5 cases are not reported.2 Abused elderly have a higher mortality rate, and tend to die earlier, than elderly people who are not abused, even those without chronic illnesses or life-threatening diseases.8

It is estimated that elder abuse costs Americans tens of billions of dollars annually, including health care, social service, investigative and legal costs, and lost income and assets.1 In fact, the financial abuse of seniors is estimated to cost more than $2.6 billion per year and is more often perpetrated by family members and caregivers.9

The global economic recession has weighed heavily on this issue. In the United States, more family members are living under one roof, increasing demands on the caregiver. More elderly have had to make difficult financial decisions, and many cannot afford health care on their limited resources. Nationwide, 2 million adults leave Medicaid and become uninsured every year.10

Elder abuse, like other forms of abuse, is a complex problem, and many physicians understandably have misconceptions about it. In the emergency department, elder abuse and neglect are less evident than child abuse and domestic violence. Emergency providers tend to think of elder abuse and neglect as affecting people living in nursing homes with poor health care service. Unfortunately, elder abuse and neglect are much more common and could be happening right next door. The American Psychological Association has presented a more accurate picture of elder abuse3:

- **Most incidents of elder abuse do not occur in nursing homes.** Occasionally, shocking reports of nursing home residents who are mistreated by the staff are brought to the public’s attention. No doubt such abuse does occur, but it is not the most common type of elder abuse. Only about 4% of older adults live in nursing homes,11 and the vast majority of nursing home residents are being cared for without being subjected to abuse or neglect.

- **Most elder abuse and neglect occur in the home.** Ninety-five percent of individuals over age 65 live on their own or with their spouses, children, siblings, or other relatives, not in institutional settings.12 When elder abuse happens, the abuser is usually a household member (89.7%) or a paid caregiver (4.2%).13 Although there are extreme cases of elder abuse, the abuse is often subtle, and it is not always easy to distinguish normal interpersonal stress from abuse.

- **There is no single pattern of elder abuse in the home.** Sometimes the abuse is a continuation of long-standing patterns of physical or emotional abuse within the family. Alternatively, abuse can develop in response to changes in the family’s living situation and relationships, brought about by the older person’s increasing frailty and dependence on others for companionship and fulfillment of basic needs.

- **Infirm and mentally impaired people are not the only elderly who are vulnerable to abuse.** Elders who are ill, frail, disabled, mentally impaired, or depressed are at greater risk of abuse, but those who do not have these obvious risk factors can also find themselves in abusive situations and relationships.6

Like other forms of violence, elder abuse is never an acceptable response to any problem or situation, however stressful it may be. Effective interventions are available to prevent or stop elder abuse. By increasing awareness among and effective
communication between physicians, mental health professionals, home health care workers, and others who provide services to the elderly and family members, patterns of abuse or neglect can be broken.

HISTORY

Since the first reports of elder abuse appeared in the medical literature more than 30 years ago,14 studies from various disciplines—medicine, nursing,15,16 social work,17 and law enforcement18,19—have attempted to define the problem. While complex related issues are being debated and interventions evaluated, the importance of the problem and the need to identify elders at risk are clear. The uniqueness of the patient’s home as the site of care has important implications for detecting and managing elder abuse and neglect. Family members and paid caregivers are more likely to be present during a home visit than during an office visit or a hospital encounter, so the interaction between the elderly person and his/her caregiver can be observed. Suspicions can be corroborated or diminished during visits, discussions can be undertaken with people entering the home (aides, therapists), and observations can be made over time. The need for support services, caregiver respite, or even emergency protection from harm can be overt, or the signs can be subtle, requiring a long-term relationship before they are identified.3

Elder abuse is now recognized internationally as a pervasive and growing problem, deserving the attention of clinicians who provide acute and chronic medical care for the elderly as well as that of the general public.20 A report from the World Health Organization on violence and health prominently featured elder abuse and highlighted the range of harmful activities covered by this term throughout the world. Examples ranged from outright physical assault of old people in modernized cultures, which, sadly, has been acculturated into so-called traditional forms of family violence, to the systematic ostracization of tribal elders by the community in some less developed countries as a form of scapegoating (eg, levying charges of witchcraft against elderly Tanzanian women and then abandoning them as retribution for natural events such as drought or famine).

The establishment of the International Network for the Prevention of Elder Abuse in 1997,21 with representation from more and less developed countries throughout the world, indicates the increasing concern about elder abuse. Along with this rising public interest, a slowly improving body of scientific work on the subject has been published. Although most research has been criticized as biased and methodologically flawed, recent investigations have used more rigorous approaches with concomitant gains in knowledge of elder abuse.4 Much of the published research comes from the United States, Canada, the United Kingdom, and other European countries,22 but additional countries are beginning to address this problem as well. For example, the World Health Association and the International Network for the Prevention of Elder Abuse held focus groups in Kenya, Lebanon, Argentina, India, and Brazil as a prelude to international collaborative research on the topic in 2001.23 Several incidence and prevalence studies have been done throughout the world, using standard case definitions and, in some studies, scientifically acceptable research methods.24 More rigorously designed risk-factor and natural-history studies have been done,22 and there are calls for intervention studies that involve rigorous randomized designs, observer masking, and attempts to standardize interventions.24 In the United States, a National Academy of Sciences panel was convened to assess the state of research on the abuse of elderly people.22 Fortunately, elder abuse is being recognized as a threat to well-being and healthy aging, worthy of interest by clinicians, epidemiologists, and health-service researchers; however, these research advances create a quandary for the busy clinician.
Research into the detection and prevention of elder abuse is complex and sometimes contradictory, and a gap exists between basic research and clinical application. Much of the epidemiologic and risk-factor research has been done by social scientists who have no first-hand familiarity with the ergonomically efficient practice of medicine, whereas clinical guidelines come mainly from the specialties of medicine and nursing. Several emergency medicine textbooks also advocate for elder abuse screening, but these lack a solid evidentiary basis or efficient protocol. Elder abuse is one of a mounting list of family and social problems that encompass the scope of contemporary medical practice, yet the time and resources needed to address them are increasingly constrained in health systems in virtually all countries.

**DEFINITION OF KEY TERMS**

Various definitions of elder abuse have been developed, separating physical, psychological, and financial acts from omissions. A general definition is the following: intentional actions that cause harm or a serious risk of harm to a vulnerable elder by a caregiver or person who stands in a trust relationship with the elder, or failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm. This definition encompasses 2 key ideas: that the old person has suffered injury, deprivation, or unnecessary danger, and that a specific individual (or individuals) is responsible for causing or failing to prevent it. It is important to consider the many forms that these acts or omissions can take and to be aware of subtle signs of abuse and neglect.

The National Center on Elder Abuse developed the following definitions for the 8 types of elder abuse and neglect (Table 1):

- **Abandonment** is the desertion of an older person by an individual who has assumed responsibility for providing care for the older adult or by a person with physical custody.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Abandonment</td>
<td>The desertion of an older person by an individual who has assumed responsibility for providing care for the older adult or by a person with physical custody</td>
</tr>
<tr>
<td>Emotional or psychological abuse</td>
<td>The infliction of anguish, pain, or distress through verbal or nonverbal acts</td>
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<tr>
<td>Financial or material exploitation</td>
<td>The illegal or improper use of an older adult’s funds, property, or assets</td>
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<tr>
<td>Neglect</td>
<td>The refusal or failure to fulfill any part of a person’s obligations or duties to an older adult</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>The use of physical force that can result in bodily injury, physical pain, or impairment</td>
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<tr>
<td>Sexual abuse</td>
<td>Nonconsensual sexual contact of any kind with an older adult</td>
</tr>
<tr>
<td>Self-neglect</td>
<td>A person’s refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication, and safety precautions</td>
</tr>
<tr>
<td>Resident-to-resident aggression</td>
<td>Negative and aggressive physical, sexual, or verbal interactions between long-term care residents</td>
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- **Emotional or psychological** abuse is the infliction of anguish, pain, or distress through verbal or nonverbal acts. It is the second most common form of elder abuse. It can take the form of verbal harassment, belittling, threatening, and scolding, and may be overt or subtle. The victim’s reactions can include withdrawal, apathy, rapid worsening of cognitive function, or new repetitive movements, such as rocking in place. Because many of these signs have a long differential diagnosis in geriatrics, a comprehensive approach is necessary, and full assessment may require several home visits.

- **Financial or material exploitation** is the illegal or improper use of an older adult’s funds, property, or assets. It involves the breaking of trust through a manipulative or exploitive (possibly illegal) act. This type of abuse is suggested by sudden changes in bank accounts or banking practices, abrupt changes in the elder’s will or other financial documents, and shortcomings in the care being provided (eg, lack of appropriate clothing) or failure to pay bills despite the availability of adequate finances. This type of abuse affects individuals from all socioeconomic statuses. Even small amounts of money or a monthly income can be a target.

- **Neglect** is the refusal or failure to fulfill any part of a person’s obligations or duties to an older adult. It can be an intentional failure to provide goods and services that are necessary for optimal health and safety, or it can be unintentional, related to a lack of resources and knowledge. This type of neglect often involves the inadequate provision of life necessities such as food, water, and appropriate living conditions. Neglect is the most common type of harm ([Fig. 1](#)). Unfortunately, it is also the hardest to prove.  

![Fig. 1. Types of elder abuse and their incidence.](Data from US Department of Health and Human Services Administration on Aging and the Administration for Children and Families. The national elder abuse incidence study. Washington, DC: National Center for Elder Abuse; 1998; and Geroff AJ, Olshaker JS. Elder abuse. Emerg Med Clin North Am 2006;24:491–505.)
Psychological neglect includes the failure to provide social stimulation, imposed isolation, and restrictions on social interactions.

Financial neglect includes the failure to use available funds (often done with the intent to preserve a presumed inheritance) for goods and services needed for an elder’s health and safety.

Neglect is usually not a willful act; it often occurs because of a lack of resources (eg, food, money, shelter) and lack of knowledge about how to request and receive assistance. Many care providers are doing the best they can, but they are physically, financially, or mentally unable to care for their loved one. The caregiver’s guilt, pride, or shame might prevent him or her from seeking help, and others do not seek help for fear of losing their loved one to a nursing home or hospital. The same psychology can be seen with victims of neglect. Fear that they will lose the companionship of their family or fear of being sent to a nursing home may prevent them from reporting that they are living in substandard or unsafe conditions. Other factors that contribute to the underreporting of elder abuse and neglect are highlighted in Box 1.

- Physical abuse is the use of physical force that can result in bodily injury, physical pain, or impairment. Physical abuse is probably the easiest to recognize,

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**Box 1**

Factors affecting the reporting and recognition of elder abuse and neglect

- Elderly people might not report or admit abuse for the following:
  - Fear of retaliation
  - Fear of being placed in a nursing home
  - Fear that the care provider, usually a family member, will get in trouble
  - Denial
  - Blaming themselves for being a burden on their care provider
  - Embarrassment and shame over being abused
  - Poor self-esteem and feeling that the abuse is deserved
  - Inability to communicate effectively, as in patients with aphasia or dementia
  - Not having knowledge of available resources

- Medical care providers might not report abuse for the following reasons
  - Might not recognize the abuse/neglect and therefore attribute the patient’s medical condition to another cause
  - Might feel constrained by time
  - Might be concerned about offending the patient and family or in denial that a family member is abusing, especially if the potential abuser is also a patient of the physician
  - Is unfamiliar with mandatory reporting laws
  - Is unfamiliar with available resources
  - Is concerned about personal safety and have a fear of involvement
  - Is unfamiliar with screening tools
  - Misinterprets the patient’s signs as indicative of another disease process

although a victim’s reluctance or inability to report it make even this form a challenge to prove. It can be extremely difficult or impossible to differentiate injuries sustained in a fall from those caused by being thrown to the ground. Physical abuse involves force or contact that is intended to cause intimidation, injury, impairment, physical suffering, or bodily harm. It can take many forms, including kicking, biting, slapping, punching, cutting, burning, shoving, shaking, force feeding, pulling hair, pinching, striking with objects, and choking. It can also include subtle forms of abuse such as forced isolation, the use of physical and chemical restraints, or not being allowed to bathe or use the restroom. Depending on the nature of the abuse, a health care provider might not see any physical indicators of it, or the caregiver and even the victim might provide a fictitious account of how the injuries occurred. Because of the potential lag between the time of injury and presentation to a medical care provider, it is imperative that the patient be interviewed separately from the care providers and asked about the infliction of abuse.

- **Sexual abuse** is nonconsensual sexual contact of any kind with an older adult. This type of intrusion should be considered if genital or breast injuries are discovered. Elders are often reluctant to admit that these acts have occurred. In some jurisdictions, suspicion of sexual abuse requires reporting to both law enforcement and social service officials. Sexual abuse is probably the least common and most understudied form of elder abuse. Tatara estimated that 1% of elderly people in the United States are sexually assaulted. Sexual abuse can also take many forms. It can be physical, as rape and sodomy or subtle, as forced nudity, indecent exposure, and indecent speech. Unfortunately, the likelihood of proving sexual abuse is low. In 2001, Burgess and Hanrahan reported the following:
  - The older the victim, the less likely that the offender will be convicted.
  - Offenders are more likely to be charged with a crime if the victim has signs of physical trauma.
  - Victims in assisted-living situations have a lower likelihood than those living independently that charges would be brought and the offender found guilty.
  - These results are particularly bothersome because the population that is least able to defend itself is the most likely to be sexually abused and the least likely to see justice served.

The elderly are certainly entitled to consensual sexual relations. Medical providers should not assume that this does not occur, and this topic should be broached in private as a routine inquiry. Furthermore, all cases of sexually transmitted disease in patients who, in the opinion of the medical care provider, lack the capacity to consent to sexual relations should be reported to the appropriate authorities as a potential sexual abuse case. The health care provider does not need to accuse or confront the potential abuser, but is obligated to alert authorities about a concern, which can then be investigated by trained professionals.

- **Self-neglect** is a person’s refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication, and safety precautions. This could mean residing in deplorable conditions without heat or water, living in a home infested with insects, or not getting prescriptions filled. Elder self-neglect is an important public health concern and is the most common form of elder abuse and neglect reported to social services. In fact, the number of reports of self-neglect to social services agencies is rising. Self-neglect is associated with increased rates of hospitalization (rate ratio 1.47, 95% confidence
interval 1.39–1.55), mortality and the severity of self-neglect is associated with the risk of death.\textsuperscript{35} Self-neglect has great relevance to health care and social services agencies and to public health professionals, legal professionals, and community organizations. Many people with this type of neglect have underlying mental disorders (dementia, depression, psychosis, or substance abuse disorders) that prevent them from understanding that they need to seek assistance, although they tend to use outpatient, emergency, and hospital services more.\textsuperscript{6,35,36}

- \textit{Resident-to-resident aggression} is “negative and aggressive physical, sexual, or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress to the recipient.”\textsuperscript{37}

Although this list of definitions is clear, each case may only have subtleties that make it difficult for the emergency physician to have an increased sense of suspicion (eg, lack of immediate family present, inconsistent visiting home health care providers, inability to know home environment, frequent provider changes or infrequent health maintenance visits, canceled visits, and vague or inconsistent details of injuries.) “It is very common for victims to move back and forth between acknowledging and denying mistreatment or accepting and refusing assistance.”\textsuperscript{38} These inconsistencies in their history should be a red flag to the physician and provide a sense of heightened awareness to suspect abuse or neglect.

\textbf{Epidemiology}

The true overall incidence and prevalence of elder abuse and neglect may never be known, as many cases go unreported or unrecognized, and research on this topic has been limited. The National Elder Mistreatment Study revealed that approximately 11\% of United States elders surveyed had experienced some type of abuse or neglect over the previous year.\textsuperscript{39} In 2004, Lachs and Pillemer\textsuperscript{20} estimated the prevalence of elder abuse to be 2\%–10\%. The range was based on the sampling methods, survey methods, and case definitions used in the studies they reviewed. Even more worrisome is the estimation by several investigators that as few as 1 in 5 to 1 in 14 cases of elder abuse are reported to authorities and that the estimated prevalence has doubled over the past decade, from 3\% to 5\%.\textsuperscript{13,40,41}

The best estimate of the incidence of elder abuse comes from a survey conducted by the National Center on Elder Abuse in 2000. The project coordinators reviewed the number of reports of elder abuse and neglect from 54 state regions (from a total of 56 “state regions” that have Adult Protective Services) for the most recent year available and found a total of 472,813.\textsuperscript{34} A similar study published in 1998 estimated the incidence of elder abuse and neglect to be 551,000 cases involving more than 450,000 victims.\textsuperscript{13,31} Finally, a survey of Adult Protective Services programs revealed approximately 381,430 reports of elder abuse and neglect in the United States in 2003.\textsuperscript{42} Unfortunately, more recent data are not available. Most experts believe the incidence and prevalence are increasing, but it is not known if the increase is related to improved reporting and recognition or a true increase in the number.

To really comprehend the prevalence and incidence of elder abuse, the data must be analyzed in the context of our aging society. According to the 2010 United States census data, individuals age 65 years and over constitute the fastest growing segment of our population. Over the past decade (2000–2010), the population aged 65 and older grew 15.1\% compared with a 9.7\% increase in the total United States population. The number of individuals between the ages of 85 and 94 years increased 29.9\% over the same decade. Individuals older than 65 years (numbering 40,267,984) now
account for 13% of the United States population. If abuse and neglect truly affect 11% of United States seniors, the number of victims is approximately 4.4 million every year. In reports published between 1993 and 2003, an estimated 1.5 to 2 million and 1 to 2 million elderly adults, respectively, were injured, exploited, or otherwise mistreated in the United States by someone they depend on for care or protection.

Unfortunately, the most common perpetrators of elder abuse and neglect are family members, usually an adult child or a spouse (Table 2). The risk is increased if the family member abuses alcohol or drugs. Many people worry about a family member being abused or taken advantage of by a paid care provider, but reports demonstrate that the elderly are actually safer when cared for by someone who is not a family member.

Elder abuse and neglect have a significant impact on morbidity and mortality rates among the elderly. One large study that adjusted for comorbidities and other factors associated with death showed that individuals who were maltreated were 3.1 times more likely to die during a 3-year period than those who were not abused. In the same study, after 13 years of follow-up, 9% of those who were maltreated were still alive compared with 41% of those who were not. Elder abuse increases the risk of dementia, delusions, depression, and placement into a nursing home. It is

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<th>Table 2</th>
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<tr>
<td>Characteristics of perpetrators of elder abuse</td>
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<tr>
<td>Men</td>
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<tr>
<td>Abandonment</td>
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<td>Physical abuse</td>
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<td>Emotional abuse</td>
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<td>Financial exploitation</td>
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<td>Home service provider</td>
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<td>Out-of-home service provider</td>
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*Cases attributed to male perpetrators are listed by subcategory. Women had a lower incidence of abuse in all categories, except neglect, which was 52.4%.*

therefore clear that elder abuse has a significant effect on the life expectancy and quality of life of our senior citizens.

**Legal Implications**

Most states have mandatory reporting requirements for elder abuse and neglect. Physicians tend to be unfamiliar with these laws and less effective than other professional groups in identifying elder abuse.\(^{51-53}\) A 2004 survey of state adult protective services programs showed that physicians made only 1.4% of the reports for elder abuse. The most common reporters of elder abuse were family members (17.0%), social services representatives (10.6%), friends (8.0%), law enforcement officers (5.3%), and nurses/aides (38%). This low level of reporting by physicians may be secondary to delegation of reporting to hospital or clinic staff, but it could also be related to the factors highlighted in Box 1.\(^6\)

A medical care provider does not need to have definitive proof that abuse or neglect has occurred to file a report. A suspicion is all that is needed, and then the appropriate authorities, generally adult protective services, can investigate the claim. Most states that have mandatory-reporting status grant immunity to providers who report their suspicions in good faith. State-specific information on reporting requirements is available on the National Center for Elder Abuse Web site,\(^{54}\) http://www.ncea.aoa.gov/ncearchot/Main_Site/Find_Help/State_Resources.aspx. Even if an investigation does not reveal intentional abuse or neglect, it can be extremely helpful to the patient and family by identifying resources that they did not know existed through other channels (Web search, social services, physician referral, and so forth). For instance, a family that is struggling to care for a loved one while they work during the day might learn about visiting nurses and adult daycare options.

However, medical care providers who believe that a patient is at risk of continued harm, whether it is from neglect, self-neglect, or abuse, are obligated to protect the patient. This might necessitate hospital admission to sort out the social situation, and it could require assessment of the patient’s decision-making capacity if he or she wants to leave against medical advice.\(^{55}\)

**Risk Factors and Recognition**

There is no stereotypical victim of elder abuse and neglect. Individuals from all races, cultures, and socioeconomic groups have been victims, and the abuse can occur anywhere (eg, in a personal home, a nursing home, or a hospital). Elderly women and the “old old” (>85 years old) are more likely to be victimized, though it is not clear if this higher risk stems from a decreased ability to report the abuse or defend oneself or the inability to escape from the situation. Most abusers (89%) are family members (see Table 2).\(^6\)

Risk factors for elder abuse and neglect are presented in Box 2. Poor health and cognitive impairment probably increase the risk of maltreatment by reducing the elderly person’s ability to report the abuse or defend himself or herself from it. Individuals who live alone are less likely to be abused, but elderly people who are socially isolated are at increased risk because they tend to have smaller support systems and the abuse is less likely to be noticed. A history of violence, mental illness, or alcohol/drug abuse increases the risk of abuse.\(^{20,56-61}\) A good patient history, including an in-depth social history, can identify most of these risk factors. Unfortunately, these areas usually are not addressed in the Emergency Department.

Health care providers must be able to recognize the signs of elder abuse and neglect. Some red flags are highlighted in Box 3. Several screening tools have been designed to facilitate the detection of elder abuse. One that is easy to complete in the Emergency Department is the Elder Abuse Suspicion Index (EASI), which consists
Box 2
Risk factors for elder abuse and neglect

- Decreased physical health, (eg, requiring more assistance with activities of daily living)
- Dementia or cognitive impairment
- Female
- History of violence
- Increased age
- Shared living arrangements
- Social isolation
- Victim or caregiver with mental health or substance abuse issues


Box 3
Red flags of elder abuse and neglect

- Signs of neglect
  - Lack of medical aids (eg, medication, walker, cane, glasses)
  - Lack of adequate food, basic hygiene, heat, water, or appropriate clothing
  - Untreated medical issues (eg, pressure sores, Foley catheters, colostomy)
  - Confinement to a bed without assistance for long periods of time

- Signs of financial abuse
  - Excessive financial gifts or reimbursements for care provided or companionship
  - Lack of amenities the patient should be able to afford (eg, heat, water, food)

- Signs of psychological or emotional abuse
  - Unexplained changes in behavior (eg, depression, withdrawn, altered mental status)
  - Isolation from family members and friends
  - A caregiver who appears to be controlling, demeaning, overly concerned about spending
    money or is verbally or physically aggressive toward the patient

- Signs of physical or sexual abuse
  - Inadequately explained injuries (eg, fractures, sores, lacerations, welts, burns)
  - Delay in seeking medical attention after an injury
  - Unexplained sexually transmitted diseases

- General signs of abuse and neglect
  - Incongruity between accounts given by the patient and caregiver
  - Vague or improbable explanations for injuries
  - Presentation of a mentally impaired patient without a care provider
  - Laboratory or radiology findings that are not consistent with the history provided

of the 6 questions presented in Box 4. Validation of the EASI occurred in family practice offices and ambulatory care settings, demonstrating a sensitivity and specificity of 0.47 and 0.75, respectively. The EASI requires less than 2 minutes to obtain. It was validated against a recognized, detailed elder abuse Social Work Evaluation (SWE). An answer of “yes” to one or more of Questions 2 through 6 should prompt concern about abuse or neglect. A screening tool created by the American Medical Association (AMA) consists of the 9 questions presented in Box 5. An answer of “yes” to any one of these questions should raise concern and prompt a more thorough evaluation.

The education of medical care providers and mandatory reporters is often promoted as a way of improving the recognition of elder abuse. Educational interventions have been shown to increase knowledge, increase the use of assessment tools, and decrease reports of abusive actions by staff. However, only Iowa requires that all mandatory reporters complete 2 hours of training within 6 months after initial employment and every 5 years thereafter. Sadly though, there has been no change in the investigation and substantiation rates since the law was enacted.

Education alone cannot increase the recognition of elder abuse, unless medical care providers actually have the time and resources to screen patients for this often occult problem. All medical providers should be educated on the screening for elder abuse. In the United States, the Joint Commission that accredits most hospitals already requires that Emergency Departments screen all patients to ensure that they are not a victim of abuse or neglect. Typically, this is thought to be a domestic violence screen but it is also meant to identify elder abuse. Electronic medical records can also be designed to prompt for elder abuse.

It is imperative that medical practitioners conduct a thorough history and physical examination, which could be instrumental in determining a patient’s risk factors and identifying signs of abuse. At least a portion of the history should be conducted in

### Box 4

**Elder abuse suspicion index (EASI)**

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<th>Questions</th>
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<tr>
<td>1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?</td>
</tr>
<tr>
<td>2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care or from being with people you wanted to be with?</td>
</tr>
<tr>
<td>3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?</td>
</tr>
<tr>
<td>4. Has anyone tried to force you to sign papers or to use your money against your will?</td>
</tr>
<tr>
<td>5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?</td>
</tr>
<tr>
<td>6. Doctor: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?</td>
</tr>
</tbody>
</table>

The patient can answer “yes,” “no,” or “unsure.” A response of “yes” on one or more of questions 2 through 6 should prompt concern for abuse or neglect.

private, without family members or care providers present, so that the EASI or AMA screening questions can be asked. A thorough physical examination should then be conducted. This examination includes completely disrobing the patient to visualize any signs of abuse. Bruises or lacerations in various stages of healing, burns, or injuries that are not consistent with the mechanism reported should alert the provider to potential abuse. Decubitus ulcers, sores, dehydration, and poor hygiene should prompt concern for neglect or self-neglect. Again, one does not have to confirm that abuse occurred to make a report; you only need to have a legitimate concern, which will prompt a more thorough evaluation of the patient and his or her living situation. The provider should ensure that their note is factual, and does not make any accusations. The document should accurately reflect the concerns of the provider, and any physical examination or emotional findings that would make them suspect that abuse could be occurring. It is especially important to consider the diagnosis for patients who have frequent Emergency Department visits for dehydration or who show unexplained weight loss or a decline in physical and cognitive function.

**SUMMARY**

Elder abuse and neglect continue to be unrecognized and underreported. Increased educational efforts for health care providers, leading to increased awareness, of this societal problem, are needed to protect our elderly patients and decrease the incidence of abuse. Physicians can make a difference in the life of an elderly person by becoming familiar with the reporting requirements and the available assistance resources.

**REFERENCES**

56. Williamson GM, Shaffer DR. Relationship quality and potentially harmful behaviors by spousal caregivers: how we were then, how we are now. The family relationships in late life project. Psychol Aging 2001;16:217–26.


APPENDIX

Sources of additional information on elder abuse and neglect:

National Center on Elder Abuse (NCEA) Program in Geriatric Medicine
University of California—Irvine
101 The City Drive South, 200 Building
Orange, CA 92868
1-855-500-3357 (ELDR)
www.ncea.aoa.gov
— a national resource center dedicated to the prevention of the mistreatment of elders

Clearinghouse on Abuse and Neglect of the Elderly (CANE)
Department of Consumer Studies and Research
University of Delaware, 297 Graham Hall
Newark, DE 19716
(302) 831-3525
www.cane.udel.edu
—the nation’s largest archive of published research, training resources, government documents, and other sources on elder abuse

Eldercare Locator—
1-800-677-1116
www.eldercare.gov
—a public service of the Administration on Aging, US Department of Health and Human Services; a nationwide service that connects older Americans and their caregivers with information on senior services