Elder Abuse

KATHERINE A. MARSHALL, DNP, PMHCNS-BC, NP, CNE, AND DEBORAH HALE, MSN, RN, ACNS-BC

According to the United States Department of Justice, elder abuse is dramatically underreported, with only 1 in 23 cases reported to Adult Protective Services. Cognitive decline is a risk factor for elder abuse, particularly financial exploitation. Abused elders are at greater risk for nursing home placement than their nonabused counterparts. One in 10 senior citizens is abused each year, and abused seniors are three times more likely to face mortality than nonabused seniors (United States Department of Justice, n.d.). Elder abuse is a problem that crosses all socioeconomic and sociodemographic strata with a higher incidence in populations with increased vulnerability factors. These factors include: community-dwelling minority elders, individuals with cognitive and physical impairment, and those with psychosocial distress. Victims of Alzheimer’s disease are 4.8 times more likely to experience elder abuse than those without cognitive impairment (Dong, 2015). Elder abuse is a complex issue that can be related to many causes, such as family dynamics, caregiving stress, and cultural factors. Home healthcare clinicians providing care to community-dwelling seniors are well positioned to assess and identify elders at risk and those suffering from abuse during routine home healthcare visits. Clinicians often feel they need convincing evidence to report a suspected case of abuse, but this is not the case. Most states have mandatory reporting for healthcare professionals; this reporting requires only a reasonable suspicion of abuse. Early detection and intervention can often prevent elder abuse by facilitating important community-based support services, and managing a variety of underlying problems and stressors.

Some cultural and societal norms actually contribute to elder abuse and limit the ability of well-intended providers to identify and assist the abused. Members of some cultures may be of the belief that what goes on in the home or behind closed doors is a private or family matter. There may also be an attitude of disrespect or insignificance for the elder member in the family. The older person may experience shame and embarrassment, making it difficult for them to seek help and reveal these painful circumstances in their family, as this would shame the family. The abused elder may fear losing their living environment and be unable to manage financially and emotionally on their own due to language barriers, recent immigration status, and emotional and financial resources (American Psychological Association, 2017).

Elder abuse can take many forms: physical, sexual, emotional/psychological, neglect, and financial. Each is detrimental to the patient’s health, but the presentation may change based on the type of abuse. Home healthcare clinicians play an important role in assessing all patients for signs of potential abuse.

Physical abuse occurs when someone causes actual bodily harm by pushing, slapping, kicking, spitting, hitting, misusing medications, force feeding, and using restraints. These physical acts may cause bruising, cuts, lacerations, sprains, hair loss, missing teeth, fractures, burns, and other traumatic injuries. Sexual abuse is rape, or acts that have not been consented to, or the individual is unable to consent to, or has been forced/compelled to consent. These victims may suffer from trauma around the rectum, vagina, breasts, and mouth.

Emotional/psychological abuse can include any of the following: humiliation, intimidation, ridicule, disregard, threatening, yelling, creating fear, bullying and blaming, controlling, harassment, coercion, isolating or withholding social contact, denial of basic rights, or incidences of overprotective behavior. Individuals suffering emotional abuse often display feelings of demoralization, depression and withdrawal,
apathy, hopelessness, tearfulness, confusion, ambivalence toward the perpetrator, insomnia, loss of appetite, unexplained paranoia, agitation, and fear.

Neglect is a form of abuse that occurs when a caregiver ignores the elder’s needs or fails to respond to needs. This can include failure to access needed medical care or appropriate services, or neglect in providing aids necessary for daily living and basic necessities such as food, fluids, and physical care. Signs of neglect can present as dehydration and malnutrition, lack of appropriate clothing and/or grooming, poor hygiene, over- or under-medication, unattended medical needs, and pressure ulcers.

Many elders, especially those with cognitive impairment are victims of financial abuse. Financial abuse can be identified as a sudden or unexplained loss of financial funds; missing material property; a sudden change of an established last will and testament; or coercion into signing or turning over of funds, property, or material goods. Financial abuse can be identified when older adults are left without resources to pay bills or buy necessities. There may have been uncharacteristic withdrawals or diversion of funds, loss, damage or disappearance of property, missing medications, refusal to spend money, a disparity of assets and living situation, extraordinary interest by others in the financial assets of the elder, and dramatic financial decisions (Phelan, 2010).

The most important strategy toward preventing elder abuse is recognizing that no one should be subjected to any of the previously mentioned types of abuse regardless of the situation or stress involved. Home care clinicians need to take proactive steps to educate patients, families, and caregivers about elder abuse. This education should promote the use of resistance care, and the use of community resources for support and to decrease isolation and stress. Clinicians should encourage family members and caregivers to identify their needs and look realistically at their stress levels to avoid caregiver burden and burnout that can lead to elder abuse. Caregivers and family members under stress and demonstrating signs of distress should be referred to counseling to help with coping and alleviating the stress and potential for abuse. Evidence of abuse should be reported promptly by the clinician to the local Adult Protective Services, as mandated by law.

The National Institute on Aging provides several resources for clinicians and concerned individuals to assist in reporting suspected cases of abuse: ElderCare Locator, 1-800-677-1116, www.eldercare.gov; the National Center on Elder Abuse, 855-500-3537, or email at nceainfo@aao.hhs.gov or https://ncea.acl.gov; The National Adult Protective Services Association, 217-523-4431, or email at www.napsa-now.org; The National Domestic Violence Hotline 1-800-799-7233 (24/7) or 800-787-3224, or email at www.thehotline.org/get-help. Finally, the United States Department of Justice at 202-514-2000 or 1-800-877-8339, or email at elder.justice@usdoj.gov, or at www.justice.gov/elderjustice (United States Department of Health and Human Services, 2016).

Wounds can heal over time and mistreatment can be stopped by removing the victim and treating the victimizer, but the scars and fear that remain with the abused elder have forever changed their quality of life. Home care clinicians can play an important role in the prevention and identification of elder abuse. Astute observation of patients, their behaviors, and environment can alert clinicians to potential abuse. Prevention through early intervention and education on resources and community support can preserve the elders’ emotional well-being and quality of life.

Katherine A. Marshall, DNP, PMHCNS-BC, NP, CNE, is an instructor, Michigan State University, College of Nursing, Lansing, Michigan. Deborah Hale, MSN, RN, ACNS-BC, is an Advanced Practice Registered Nurse, Optimal Care Inc., Bingham Farms, Michigan. The authors declare no conflicts of interest. Address for correspondence: Katherine A. Marshall, DNP, PMHCNS-BC, NP, CNE, Michigan State University, College of Nursing, 1355 Bogue Street, East Lansing, Michigan, 48824 (katherine.marshall@hc.msu.edu).

Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved. DOI:10.1097/NHH.0000000000000648

REFERENCES


