ELDER ABUSE: A NEGLECTED SYNDROME

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Elder physical, psychological and financial abuse and self-neglect are prevalent, but may be overlooked by physicians who treat the elderly. Epidemiological studies in Canada and U.S.A. estimated that 4% of the elderly >60 were victimized, and this increased with age, associated with increased mortality. Most geriatricians agree that knowledge of the home situation and sensitivity to victims' wishes may effect a more positive outcome. Abuse may occur by the caregiver as the burden increases. Additional assistance may remedy the abuse or neglect, and allow the patient to continue at home. However, abuse may be intentional by family. Geriatricians and generalists can play a vital role, especially when the situation is revealed on comprehensive assessment by an interdisciplinary geriatric team, with effective intervention.

Key words: Elderly, geriatrics, abuse, self-neglect

Elder maltreatment occurs at a rate that would appear to effect *a significant proportion* of community-dwelling elders, resulting in increased mortality and reduced quality of life for those who are victimized.[1] Despite the fact that the phenomenon of elder abuse reached public awareness in the 1970s, it continues to have step-child status when compared with child abuse and spouse abuse. In the medical arena, physicians, who are strategically positioned to detect, intervene, and monitor cases of elder abuse and neglect,[2] have been noticeably lax both in detecting abuse and neglect and in contributing to the knowledge base concerning this problem.

Whereas the phenomenon of child abuse has benefited greatly from the powerful advocacy of pediatricians, elderly victims lack a comparable lobby. Not only are there fewer geriatricians, but also geriatrics as a specialty is less developed and consequently less influential at a policy level.

Less is known about the prevalence or the incidence of elder abuse than what is known about that of child and spouse abuse. Estimates of the prevalence of elder abuse vary from 32/1000, based on a random sample of community-dwelling elderly persons in the Boston metropolitan area[3] to 9.6%, based on a case record review of clients referred to a Cleveland Chronic Illness Center.[4] An epidemiologic study in Canada by Podnieks[5] estimated about 4% of the elderly population were victimized. She identified financial abuse occurring most frequently; however, she defined this form of abuse quite broadly, such that the potential for false positives seems high. On the other hand, her methodology may have caused the problem to be underestimated. Her investigation consisted of a telephone survey and thus may have failed to identify many victims who did not have access to a telephone. In the United States, data compiled from Adult Protective Service agencies suggest that approximately 4% of those over the age of 60 years have been victimized and that the rate increases with age.[6] In a recent longitudinal study of a community-dwelling elderly population in Connecticut,[7] 6.4% were found to have been victimized at some time since age 65. This study also reported increased mortality as an outcome and cited self-neglect as the most commonly reported type of abuse and neglect.

Extrapolating from these findings to estimate a national percentage is difficult. Inconsistencies in definition of abuse may vary from state to state in the United States, with certain types being included in one but excluded in another, thus resulting in widely fluctuating estimates of prevalence. Similar variation occurs among researchers. Pillemer and Finkelhor[3] excluded material abuse in their study, whereas most U.S. States identify material abuse as a reportable offense. Some states exclude the problem of self-neglect from the definition, particularly if the victim is determined to be competent. Most studies, however, attest to the fact that elder-abuse, even when detected, is under-reported. Pillemer

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and Finkelhor[3] noted just 1 in 14 cases was reported to any official agency.

The gravity of the problem is attested to by the fact that elderly victims appear to have an increased risk of dying. In a longitudinal study of 2,812 community-dwelling elderly individuals, the reported 13-year survival-rate for those who were victimized was 9% vs 40% for those who were not victims of abuse, and 17% for those identified as victims of self-neglect.[1]

DEFINITION

There is much disagreement about what constitutes abuse, with a plethora of definitions across the USA and Canada. The American Medical Association defines abuse and neglect as "*an act of omission or commission that results in harm or threatened harm to the health and welfare of an older adult*."[8] Many different types of abuse have been identified including physical abuse and neglect, psychological abuse and neglect, financial abuse, violation of rights, and more recently the problem of self-neglect has emerged in the literature as perhaps the type of maltreatment that has the greatest prevalence. Abuse and neglect *vary* greatly in severity from homicide or suicide to milder forms that hover between normal and abusive behavior. In some instances, abuse like beauty may be in the eye of the beholder.

REPORTING AND INTERVENTION

Many states in the United States, in contrast with Canada, obligate physicians and others to report suspected abuse and neglect even if this is contrary to the victim's wishes. In many instances this is an appropriate response, with Adult Protective Services responding in a timely manner and securing appropriate assistance. In other instances, this is potentially problematic in that such an action may not serve the needs of an older person and may possibly result in further harm and infantalize the victim. Most physicians, especially geriatricians, feel that the application of good judgment with knowledge of the home situation and sensitivity to victims' wishes is likely to effect a more positive outcome than routinely involving an unfamiliar state agency whose intervention may be viewed as punitive.

It is evident that there are many cases of abuse and neglect where the abuser may also be the caretaker and may have no malicious intent to harm the victim but is overwhelmed by the care-giving role. This commonly occurs when care is provided to a demented individual where the caregiver burden increases over time. In these situations the abuse may be reciprocal.[9] Provision of additional services and assistance in the home may remedy the situation and allow the victim to continue to live at home. However, many instances of abuse are perpetrated intentionally by family members, and in those instances all available state and legal resources need to be mobilized.

A ROLE FOR GERIATRICIANS

The opportunity for all physicians to have a positive effect on this problem is great. Assessment and intervention provided to victims of abuse and neglect does falls within the purview of the geriatrician and the interdisciplinary team. This is most apparent in the more complex situations where the intervention may require a comprehensive assessment including physical, functional, and mental status evaluation with attendant assessment of social support and home situation and especially if a determination of competence is required. On occasion, a combined intervention using social service agencies, the court system and the police may be required. This may be more easily accomplished by an interdisciplinary geriatric team than by a solo physician operating in isolation.

The need for geriatricians and generalists and other physicians to contribute to the knowledge base is great. The exploration of causal factors, development of strategies for early detection and effective intervention including best-practices, and the generation of outcome data are urgently needed.

The education of all physicians, but in particular primary care physicians, orthopedists, gynecologists, psychiatrists, trauma surgeons, and emergency room physicians, regarding detection and intervention in abuse situations is urgently needed. The education of physicians to work collaboratively with other health-care professionals, including nurses, social workers, and other agencies, is emphasized.

There is a great need to make state and provincial laws more consistent so that national standards and responses may be created. This is likely to result in the generation of more accurate national data regarding prevalence. The whole reporting process needs to be simplified for physicians, so that with one telephone cal,l an appropriate response can be

activated, providing adequate assistance in the least disruptive manner with continuing communication between all groups involved. This is the intent with new model laws being developed in the state of Kentucky.

Geriatricians can contribute additionally by identifying gaps and inadequacies in the current system and advocating for change *with the intent of elevating the problem of elder abuse and neglect at least to the level of child abuse and neglect*.

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CONCISE OXFORD TEXTBOOK OF MEDICINE

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Overall Rating: Very good.

These are tenuous times for 'textbooks' of all stripes, let alone Textbooks of Medicine. Increasing fragmentation of the marketplace and advances of electronic means over print media make it ever more difficult to establish a significant presence. Focus on evidence-based medicine and increasing ease of accessing sources of information from all data bases makes the use of textbooks much less frequent. Medical practice is becoming ever more compartmentalized and sub-specialized. It is evolving faster than ever. Is there a role for a new textbook that takes a bird's eye view of the whole of internal medicine? The answer – a resounding *yes* indeed.

The editors argue that there will always be a need for a reference that gives us an entry point for any disease that we encounter, that points us in the right direction when we wish to analyze our patients in more detail, that offers a reasonable grounding in both the scientific and pastoral aspects of internal medicine and that presents a more than usual global perspective of disease and illness. These are the goals that the editors set for themselves, and they achieve these goals admirably the vast majority of the time.

Target Audience: The editors identify their audience as medical students, physicians in training, general practitioners and general internists.

Strengths: Clear organization, comprehensiveness, and multiple references for further reading when greater detail is desirable. The layout is excellent and each section follows a logical and easily usable outline.

Weaknesses: Given the vastness of the area covered, it is understandable that some areas are covered superficially. There are only two chapters focusing on gerontology, titled; 'Medicine in old age' and 'Abuse of elderly people'. Some references for further reading are dated (e.g. 1952); more aggressive editing for this offspring of Oxford Textbook of Medicine would correct this.

Overall: A useful tool in a busy family physician's office. Very handy as a quick reference or as a guide for further reading on any subject in the area of internal medicine.

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