Workshop: Elder Abuse and its Prevention—IOM
April 17-18, 2013
Section on Risk and Protective Factors and Adverse Health Outcomes

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Why “Mistreatment,” Not “Abuse?”
(NRC Report: 2003)

- Not all phenomena are overt physical violence
- Complexity of interaction in the home is more likely to have bi-directional elements
- “Abuse” is more likely to be used in legal language;  
  *not all mistreatment is a crime*
Three Components of Elder Mistreatment

- Trust relationship
- Intent and motivation
- Harm in some form
How Do We Identify Elder Mistreatment?

- Surveys of older people themselves (and proxies)
- Medical encounters/ records
  - Clinical record review; imaging, other biomarkers
  - Professional reports and referrals; screening procedures
- Surveys of other professional and lay observers
  (community and institutional)
- Social and legal encounters/ records
  - Police and court records
  - Adult protective services; other social service/ inst. records
  - Coroner and medical examiner records
- Monitoring: personal, social and fiscal (cameras;
  physiological sensors; changes; banking records, etc)
All Methods are Useful; All are Flawed

1. Inadequate coverage of populations
2. Difficult E.M. definitions
3. Challenges of event validation
4. Background “noise” of health, social, legal complaints
5. Risk factors differ by type of E.M. and settings
6. Limitations of surveys (e.g., cognitive impairment; proxies may be perpetrators; most vulnerable least likely to participate—e.g., mental/ other chronic illness)
7. Poor health and social outcomes very common among potential/ actual victims
8. Flawed assumptions of caregiver/ family roles, relations
Some Definitional Issues

- Conflicts with other definitions of vulnerable, disabled adults
- Assessing intent/motivation for EM
- The role of legal and administrative definitions even within a jurisdiction
- Is refusing to provide for someone else a social issue, a moral issue, a crime?
- Iatrogenic events and other errors in professional practice
A Legal Issue Resulting from Elder Abuse Law

Under-treatment of pain in clinical setting:
Mistreatment or malpractice, or both?

– Multiple settings (home care, hospice, nursing homes, hospitals)
– Circumventing usual litigation pathways
– Lack of training in pain medicine
– Reticence to use pain medicine to the fullest
The Complexity of Social Interactions: EM in the Institutional Setting?

- Forcing a resistant elder to wash her hair twice a week?
- Using chemical restraints to improve patient safety?
- Not honoring holidays of all faiths in a long-term care facility?
- A capable family member who ignores an elder in a long-term care facility?
- Not providing a chapel in a long-term care facility?
Some Consequences of Elder Mistreatment

Physical Health
- Morbidity (skin wounds; fractures, etc.)
- Death; dysfunction and disability

Psychological Health
- Depression; fear; guilt; shame; distrust; learned helplessness; withdrawal; post-traumatic stress syndrome

Social
- Loss of companionship; family disruption

Economic Status
- Loss of resources, possessions
Risk Factors for Elder Mistreatment

- Victim dependency/ vulnerability
  - Poor health; disability/functional impairment; poor personal defenses; poverty; possibly dementing illnesses (resp. to behav.)

- Gender--women

- Abuser dependency/deviance
  - Alcohol and drug abuse; mental illness; poor employment record

- Social isolation
  - Abuse undetected; lack of social support to buffer stress

- Living arrangements
  - Shared living arrangements; greater opportunity for tension and conflict; long term care facilities

- Resources to exploit
Risk Factors for Being a Perpetrator
[The Gerontologist 38:471-480]

Abusive Caregiver Characteristics:
- Alcohol and substance abuse;
- Mental health problems: depression/ personality disorder; behavioral problems; care-giving reluctance, inexperience
- Poor interpersonal relationships; premorbid relations
- Current marital, family conflict;
- Lack of empathy, understanding of care needs and issues
- Financially dependent on victim
Levels of Prevention for Disease: Definitions

- **Primary**: Preventing the onset of a disease or condition before it occurs
- **Secondary**: Early and asymptomatic detection of disease or condition (“screening”)
- **Tertiary**: Preventing the progression and consequences of an overt disease or condition

*This typology may not fully fit social or criminal events*
A Complex Theme: Defining Levels of Mistreatment Prevention in the Face of Chronic Illness

- Primary Prevention
- Secondary Prevention
- Other Int’ns

Chronic Illness

Lifecourse
The Clinical Recognition of EM: (Screening—Secondary Prevention)

1. Frequent primary care or ER visits
2. Frequent or unexplained falls
3. Injuries inconsistent with explanations given
4. Evidence of neglect: malnutrition, dehydration, hypotherm.
5. Overmedication: poisoning, stupor
6. Undue physical restraint
7. Inappropriate clothing
8. Inadequate aids and devices
9. Lack of money, possessions; social isolation
Some Possible Newer Approaches to EM Risk Factors and Prevention
1. Considering Aging in Society

- Position of older people in society
  - Agism
  - Human rights
  - Larger social and cultural attitudes
  - Going beyond interpersonal relations
  - Social exchanges and transactions

*Int Psychogeriatr. 2013 Feb 8:1-8*
2. Geographic Context of EM Violent Crime Mapping (National Geographic)
Google Street View®: Assessing Poverty
3. Lifecourse Experience and Victimization
A Possible Role for Adverse Childhood Experiences?

  - Unwanted sexual intercourse < 16 years: RR = 3.5
  - Rape < 16 years: RR = 2.6
  - Severe beatings by parents or carers: RR = 3.6

- Childhood Abuse and Attempted Suicide [JAMA 286:3089]
  - Emotional abuse: RR = 5.0
  - Sexual abuse: RR = 2.8
  - Battered mother: RR = 2.6
  - Mentally ill household member: RR = 3.3
  - Parents separated/divorced: RR = 1.9
4. Is there a Genetic Effect on EM: Early Childhood Abuse and Adult Behavior

[Science 297:851]

**Fig. 1.** Means on the composite index of antisocial behavior as a function of MAOA activity and a childhood history of maltreatment (27). MAOA activity is the gene expression level...
5. Development of Potential Screening “Biomarkers” of Abuse/Neglect

- Blood biomarkers--examples for consideration: myoglobin; acute phase reactants
- Patterns of fractures; morphology
- Morphology and distribution of bruising
- Quick tests of malnutrition and dehydration
- Forensic testing—similar to assault and rape investigations
6. A Role of Forensic Science: A Midwestern Program Ten-Year Experience

Cases over 60 including homicide and neglect

<table>
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<th>Homicide (avg age 72.1)</th>
<th>Neglect (avg age 79.7)</th>
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<tbody>
<tr>
<td>Gunshot</td>
<td>42%</td>
<td>Pneumonia</td>
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<tr>
<td>Beating</td>
<td>37</td>
<td>Sepsis</td>
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<tr>
<td>Stabbing</td>
<td>19</td>
<td>Dehydration</td>
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<tr>
<td>Asphyxia</td>
<td>10</td>
<td>Heart disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fall</td>
</tr>
<tr>
<td></td>
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<td>Undetermined</td>
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[J. Forensic Sci. 49:122]
The Role of Forensic Science: A Midwestern Program Ten-Year Experience - II

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<tr>
<th></th>
<th>“Homicide” cases</th>
<th>“Neglect” cases</th>
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<tbody>
<tr>
<td></td>
<td>(N = 52)</td>
<td>(N = 22)</td>
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<table>
<thead>
<tr>
<th>Perpetrators</th>
<th></th>
<th>Residence</th>
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<tbody>
<tr>
<td>Spouse</td>
<td>15%</td>
<td>With family</td>
</tr>
<tr>
<td>Other family</td>
<td>10</td>
<td>Non-fam. caretaker</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>10</td>
<td>Alone; non-fam. caretaker</td>
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<tr>
<td>Undetem.</td>
<td>73</td>
<td>Nursing home</td>
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<tr>
<td></td>
<td></td>
<td>Unknown</td>
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7. Elder Monitoring and Telemedicine

- Citizen or patient routine health reporting and monitoring
- Physiological monitoring
- Voice analysis for stress or health change
- Sensors assessing quality of social interaction (part of “smart housing”)
Summary: Preventive Considerations in EM

- Multiple sources of evidence exploration
- Need for lifecourse approaches
- Evidence-based programs
- Efficiency
- Community and personal (family) approaches
- Context of all preventive needs