



READING BETWEEN THE LINES

ELDER ABUSE



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ANCC Accredited NCPD Hours: 2 hrs

Target Audience: RN/APRN

NEED ASSESSMENT

Elder abuse is a pervasive global human rights issue, characterized by the mistreatment of older adults through acts of commission or omission that result in harm—or risk of harm—within the context of a trusted relationship. This mistreatment can manifest in various forms, including physical, emotional, sexual, and financial abuse, as well as neglect and abandonment.

According to the United States Department of Justice, elder abuse may involve:

- **Isolation or neglect** by an adult child or caregiver
- **Physical or sexual assault** by an intimate partner, caregiver, or family member
- **Financial exploitation** by a relative, professional, or even a stranger

- **Neglect by a cognitively impaired partner**, such as one with advancing dementia
- **Systemic neglect** in institutional settings, including long-term care facilities, leading to inadequate or substandard services

Although many of these forms of abuse are illegal and may warrant legal intervention, perpetrators are infrequently prosecuted. This lack of accountability not only fails to deliver justice but also diminishes deterrence, thereby allowing abuse to persist.

As the global population continues to age, there is an urgent and growing need for healthcare professionals—particularly physicians and advanced practice providers—to be equipped with the skills to recognize, assess, and intervene in cases of elder abuse. Early identification and appropriate management are

essential to protect vulnerable older adults and uphold their dignity, rights, and quality of life.

OBJECTIVES

- Define elder abuse and explain its classifications.
- Discuss the epidemiology and prevalence of elder abuse globally and within local healthcare.
- Identify risk and protective factors associated with elder abuse
- Recognize the clinical manifestations and warning signs of elder abuse
- Identifying Intimate Partner Violence (IPV) as a Component of Elder Abuse
- Describe the outcomes of elder abuse
- Discuss the strategies to identify elder abuse
- Discuss the Management Principles to Address Elder Abuse
- Discuss the preventive measures of elderly abuse in nursing perspectives

GOAL

The goal of this article is to explore the incidence, prevalence, and multifaceted impact of elder abuse, while emphasizing the critical role of nurses in its early identification and effective intervention. It aims to equip nursing professionals with evidence-based strategies to recognize signs of abuse, respond

appropriately, and fulfil their legal and ethical responsibilities regarding mandatory reporting, in alignment with current regulatory standards.

INTRODUCTION

Elder abuse is increasingly recognized as a significant public health and human rights concern, with serious implications for the well-being and survival of older adults. It is associated with markedly higher rates of hospital admissions, long-term care placement, and mortality. While prevalence estimates vary, recent studies suggest that approximately **5% to 10%** of older adults report experiencing some form of abuse.

The issue is inherently complex, making research in this area particularly challenging. Elder abuse is a broad term encompassing various forms of mistreatment—**physical, psychological, sexual, and financial abuse**, as well as **neglect**. Each subtype may have distinct risk factors, causal mechanisms, and require tailored interventions. Compounding the issue, many older adults affected by abuse are **cognitively impaired, socially isolated, or physically frail**, and often maintain **complex, dependent relationships** with their abusers.

The sensitive nature of abuse also raises significant **ethical and practical challenges** for researchers. Collecting accurate data may pose emotional, legal, financial, and social risks

to both victims and perpetrators, often resulting in intentional concealment of abuse. These dynamics further complicate the ability to conduct reliable and ethically sound research involving a vulnerable population.

As a result of these barriers, **evidence remains limited** regarding the effectiveness of both **screening tools** and **intervention strategies**. This gap in knowledge underscores the urgent need for enhanced clinical awareness, interdisciplinary collaboration, and the development of best practices for the **identification, prevention, and management** of elder abuse. [1, Rank 5]

ELDERLY ABUSE

Elder abuse is broadly defined as *“a single or repeated act—or lack of appropriate action—occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.”*

This definition emphasizes the central role of trust and the potential for both **acts of commission** (intentional harm) and **acts of omission** (failure to act) to result in abuse.

Elder abuse encompasses a range of behaviors, each with distinct characteristics:

- **Physical Abuse:**

Intentional actions causing physical pain or injury, such as hitting, kicking, slapping, pushing, or inappropriate use of medications or physical restraints.

- **Psychological (Emotional) Abuse:**

Behaviors intended to cause emotional distress, including humiliation, threats, intimidation, verbal assaults, social isolation, or manipulation.

- **Sexual Abuse:**

Any non-consensual sexual act involving an older adult, including those to which the person could not consent due to cognitive or physical impairment, or was coerced into consenting.

- **Financial or Material Exploitation:**

The unauthorized or improper use of an older adult’s funds, property, or assets. This includes theft, fraud, coercion to alter wills or financial documents, and undue influence over financial decisions.

- **Neglect:**

The failure of a caregiver to fulfill basic caregiving responsibilities, including providing adequate nutrition, medication, hygiene, shelter, and access to healthcare services.

The **U.S. National Academy of Sciences** has further expanded on this with a widely accepted scientific definition of elder abuse:

“(a) Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship; or (b) Failure by a

caregiver to satisfy the elder’s basic needs or to protect the elder from harm.”

This definition underscores two critical elements:

1. That the older adult experiences **harm, deprivation, or risk** of unnecessary danger.
2. That the **perpetrator is someone in a trusted relationship** who either causes the harm or fails to prevent it.

Across clinical, legal, and academic settings, there is broad agreement on these five core types of abuse:

- Physical abuse
- Psychological/emotional abuse
- Sexual abuse
- Financial/material exploitation
- Neglect

This shared framework helps guide **screening, reporting, intervention, and legal accountability**, and underscores the need for vigilance in identifying abuse in any setting where older adults may be vulnerable.

5 core types of ABUSE



PREVALENCE OF ELDER ABUSE

Emerging data from various states and countries highlight the urgent need to address the widespread issue of elder abuse. While some early population-based surveys have been criticized for vague definitions and methodological inconsistencies, more recent large-scale studies conducted among **community-dwelling older adults** provide stronger and more reliable prevalence estimates.

It is important to note that these reported rates are likely **underestimations** of the true prevalence. Older adults often underreport abuse due to fear, shame, cognitive decline, dependency on caregivers, or lack of awareness that what they are experiencing constitutes abuse.

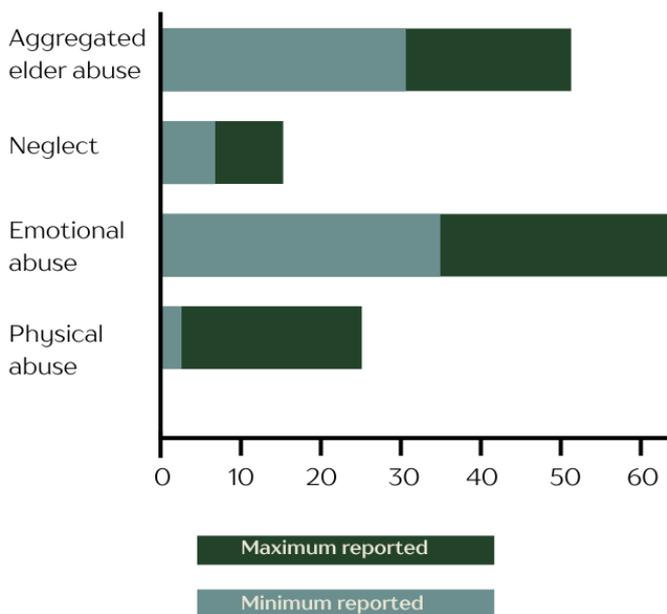
Elder abuse research is often categorized into two main settings:

- **Community-dwelling populations**
- **Institutionalized older adults** (e.g., those in nursing homes or long-term care facilities)

Reported prevalence rates from recent studies include:

- **Physical Abuse:**
- Ranges from **1.0% to 23.1%**
- **Emotional/Psychological Abuse:**
- Ranges from **27.9% to 62.3%**

- **Neglect:**
Ranges from 4.0% to 15.4%
- **Sexual Abuse and Financial Exploitation:**
Specific prevalence rates were **not consistently reported** in several studies
- **Aggregated Elder Abuse (any form):**
Ranges from 27.9% to 52.0%

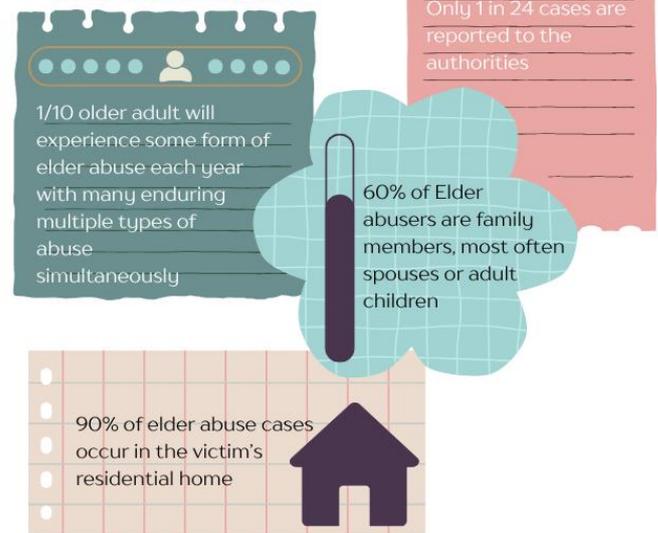


Notably, **elder abuse prevalence is significantly higher among older adults with cognitive impairment**, such as those with dementia, compared to their cognitively intact counterparts.

These findings underscore the pressing need for improved detection, prevention strategies, and tailored interventions, particularly in high-risk subpopulations. [7, Rank 2]

EPIDEMIOLOGY AND PREVALENCE OF ELDER ABUSE: GLOBAL AND LOCAL PERSPECTIVES

Elder Abuse Statistics in 2023



Elder abuse is a significant and growing public health issue globally and within local healthcare systems, affecting approximately one in six individuals aged 60 years and older, according to the World Health Organization. It encompasses various forms—including physical, psychological, financial, sexual abuse, and neglect—often occurring within relationships of trust. Global prevalence estimates suggest psychological abuse is most common, followed by financial exploitation and neglect, though underreporting is widespread due to fear, stigma, cognitive

impairment, and dependency on abusers. In institutional settings such as nursing homes and hospitals, abuse—particularly neglect—can go unnoticed due to staffing shortages, caregiver burnout, and lack of training. Locally, healthcare providers may miss signs of abuse due to limited screening protocols and ambiguous reporting systems. Strengthening awareness, implementing mandatory reporting policies, and integrating routine assessment into clinical practice are essential strategies to identify and address elder abuse across care settings.



RISK FACTORS FOR ELDER ABUSE

Elder abuse is a complex, multifactorial issue influenced by a combination of individual,

relational, and environmental factors. Numerous studies have identified several key risk factors that increase the vulnerability of older adults to abuse across different settings.

1. Risk Factors Related to the Older Adult

- Cognitive impairment, such as dementia, which can hinder the ability to recognize or report abuse
- Behavioural disturbances, including aggression, wandering, or agitation
- Psychiatric illness or emotional distress, such as depression or anxiety
- Functional dependence, requiring assistance with activities of daily living (ADLs)
- Poor physical health or frailty, increasing reliance on others for basic needs
- Low income or financial insecurity, making the individual more susceptible to financial exploitation
- History of trauma or past abuse, which may influence coping mechanisms and recognition of mistreatment
- Ethnicity, with some studies noting increased risk among certain groups (e.g., higher rates of financial abuse in African Americans and physical/sexual abuse in Canadian Aboriginal populations)

2. Risk Factors Related to the Perpetrator

- Caregiver stress or burden, often due to long-term responsibilities without adequate support
- Mental health issues, including depression, substance abuse, or other psychiatric disorders

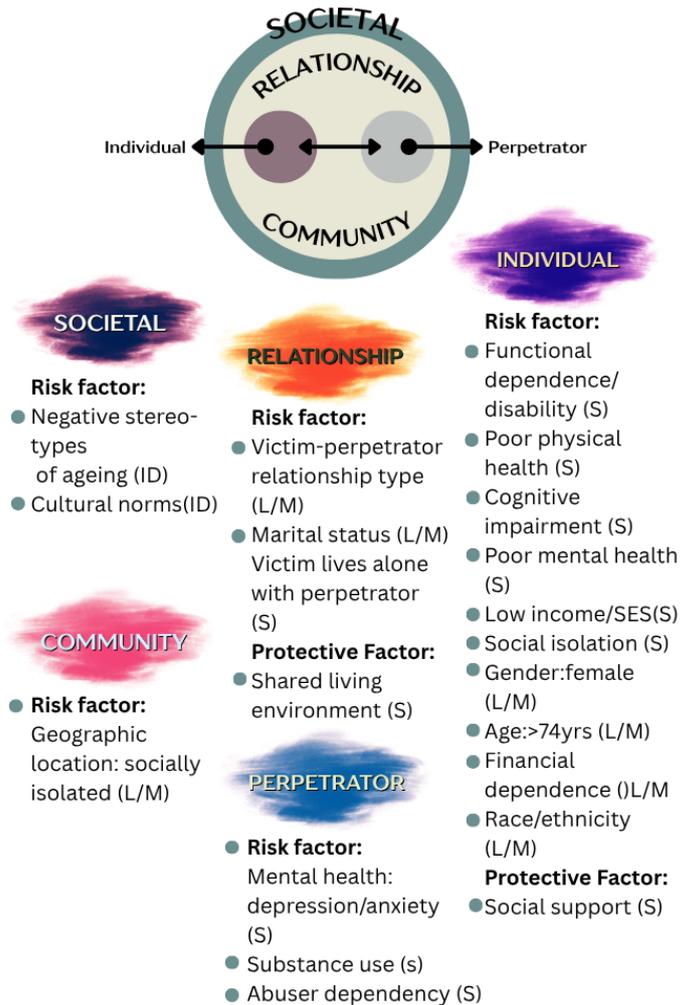
3. Risk Factors Related to the Relationship

- Family conflict or strained interpersonal relationships, including unresolved resentment or longstanding disharmony
- Power imbalances, particularly in dependent caregiving relationships, can facilitate abuse

4. Environmental and Social Risk Factors

- Low levels of social support or isolation, reducing opportunities for detection and intervention
- Living arrangements, especially cohabitation with others, which is associated with increased risk (except in cases of financial abuse, where isolation is more common)

This framework highlights that elder abuse is rarely the result of a single factor but rather the interplay of multiple vulnerabilities. Tailored prevention strategies must consider these diverse risk domains to effectively protect older adults. Let me know if you'd like this formatted into a table, flowchart, or visual representation.



CLINICAL MANIFESTATIONS OF ELDER ABUSE

The clinical manifestations of elder abuse are often subtle, variable, and difficult to distinguish from age-related conditions or accidental injuries, making detection particularly challenging. These presentations can differ based on the **type of abuse** and the physical or cognitive status of the older adult. A review of **forensic markers of elder abuse**—key factors used in medical and legal evaluations—identified several indicators that warrant suspicion and further assessment.

Common clinical features include:

- **Skin injuries** in unusual locations, such as abrasions, lacerations, bruises, or burns that are inadequately explained or inconsistent with the older adult’s history or mobility status
- **Fractures**, particularly **spiral fractures of long bones** or fractures in areas uncommon for typical falls (e.g., ribs, sternum, scapula), especially in nonalcoholic older adults
- **Malnutrition and dehydration**, indicative of neglect or intentional withholding of care
- **Pressure ulcers** (bedsores), often resulting from prolonged immobility and poor caregiving practices
- **Genitourinary signs**, including unexplained **vaginal or rectal bleeding**, **sexually transmitted infections**, or **pain in the oral or anal–genital regions**, which may signal sexual abuse
- **Poor hygiene, soiled clothing, or unsafe living conditions**, which may reflect both active and passive neglect

Clinicians must maintain a high index of suspicion when these signs are present, particularly in vulnerable older adults with limited ability to communicate. A careful assessment of injury patterns, discrepancies between history and findings, and the psychosocial context is critical to identifying abuse and initiating protective interventions.



PHYSICAL ABUSE

- Unexplained bruises, burns or injuries
- Frequent falls or fractures
- Restraining marks or evidence of physical restraints

EMOTIONAL ABUSE

- Withdrawal from activities and social interactions
- Sudden changes in behavior or mood
- Unexplained fear or anxiety



PSYCHOLOGICAL ABUSE

- Verbal insults, humiliation or threats
- Isolation from family, friends or support networks
- Signs of depression, anxiety or withdrawal



SEXUAL ABUSE

- Unexplained sexually transmitted infection or disease
- Bruising/Signs of trauma in genital areas
- Fearful/Distressed behavior in the presence of certain individuals



NEGLECT

- Poor personal hygiene including dirty clothes and unkempt appearance
- Malnutrition or dehydration
- Unsafe or unclean living conditions

FINANCIAL ABUSE

- Unusual/unexplained financial transactions
- Missing personal belongings or cash
- Sudden changes in financial situations or inability to pay bills



NEGLIGENCE BY CARE GIVERS

- Failure to provide necessary medical care or medications
- Ignoring or disregarding the elder’s needs
- Inadequate supervision or abandonment

THE IMPORTANCE OF IDENTIFYING INTIMATE

PARTNER VIOLENCE (IPV) AS A COMPONENT OF ELDER ABUSE

Intimate Partner Violence (IPV) in older adults is a critical yet often overlooked subset of elder abuse, encompassing a spectrum of physical, sexual, psychological, and financial harm inflicted by a current or former spouse or intimate partner. IPV includes not only overt acts of violence but also controlling behaviours such as verbal insults, humiliation, isolation, stalking, and economic exploitation. The Centres for Disease Control and Prevention (CDC) defines IPV broadly to include both actual and threatened acts, recognizing the diverse and insidious ways abuse may manifest in intimate relationships.

Prevalence estimates of elder IPV vary significantly, ranging from 2% to 25%, reflecting underreporting, societal stigma, and generational norms that may normalize abusive dynamics. Importantly, two distinct patterns of elder IPV have been identified:

- “IPV Grown Old” refers to a long-standing pattern of abuse that has persisted throughout the couple’s relationship and continues into late life. The dynamics of power, control, and coercion remain consistent as the couple ages.
- “Late-Onset IPV” describes abuse that emerges later in life, often triggered by life transitions such as retirement, changing

family roles, age-related sexual dysfunction, or the onset of cognitive decline. These stressors may disrupt existing relationship dynamics, leading to the initiation of abusive behaviors.

While studies suggest that rates of IPV victimization tend to decline with age, the physical and psychological consequences for older women are comparable to those experienced by younger victims. Older individuals may also face additional barriers to seeking help, including dependency on the abuser, fear of institutionalization, diminished social support, and cultural or generational beliefs that discourage disclosure.

Given these complexities, healthcare providers—particularly nurses—must remain vigilant in screening for IPV as part of comprehensive elder abuse assessments. Recognizing IPV in older adults is essential to ensuring safety, providing appropriate interventions, and supporting long-term recovery.

GENDER DIFFERENCES IN ELDER ABUSE

Studies reveal that older women were more likely to experience elder abuse than older men. Older women are more likely to outlive their partners. This longevity increases the possibility of exposure to risk factors for elder abuse, such as loss of independence and cognitive impairment. For older women, elder abuse may

be a continuation of intimate partner violence (IPV) into old age, in most reported cases of which women are the victims and men the perpetrators. In a systematic review and meta-analysis, no significant difference was found in the prevalence of elder abuse between older women and men in the Americas, whereas gender differences have been reported by similar studies performed in the Asia–Pacific and Eastern Mediterranean regions. Gender differences or symmetry in abuse victimization must be considered in the context of the social and cultural milieus surrounding gender roles.

There is an association between action of IPV and traditional gender roles, and traditional gender roles are linked to structural gender inequalities. That is, patriarchal societies promote maintenance of the traditional male dominance over women, which is associated with IPV. Older women and residents of non-Western countries were more likely to be abused than those living in Western countries due to differences in family structure.

One study found that the majority of perpetrators of elder abuse against men and women were friends or neighbours, followed by others. This is in contrast to other reports that most perpetrators are family members, such as the spouse or adult children. This difference may be due to the broad questions used for screening elder abuse. The caregiving neglect and financial neglect items inquired about experiences of elder abuse by a family

member or caregiver. Also, the financial exploitation items asked specifically about elder abuse by any other person and focused on negative social behaviours, not illegal or criminal behaviours. Such broad questions may have resulted in capturing a greater variety of types of elder abuse. [13, Rank 3]

INTIMATE PARTNER VIOLENCE STATISTICS



1	About 1 in 5 women and About 1 in 7 men report having experienced severe physical violence from an intimate partner in their lifetime
2	About 1 in 5 women and About 1 in 12 men report having experienced contact sexual violence from an intimate partner
3	About 10% of women and About 2% of men report having been stalked by an intimate partner

CAUSES FOR GENDER DIFFERENCES IN ELDER ABUSE

The following risk factors for elder abuse differ by gender: socioeconomic status (education and household income), relationship with children, and self-rated health. In other words, socioeconomic status is significantly associated with a higher risk of elder abuse in older men, and physical health status and relationship with children in older women. However, there is a significant interaction effect only between gender and the lowest education level. This result suggests that gender difference in prevalence and correlates of elder abuse may reflect in part to differential exposure to various living conditions patterned by social

gender roles, while potentially higher susceptibility to elder abuse in the lowest educational group among men may also play a role.

Men as the breadwinners tend to engage in marketable activities, whereas women tend to play a social role as a homemaker by engaging in domestic and supportive behaviours such as childcare, cooking, and sewing. The loss of social roles in the family with age may result in losses of power and function in older adults, increasing their vulnerability to elder abuse. Several studies in part support the social-exchange theory of elder abuse, in which the power, in terms of social status and personal resources (e.g., money, power, the ability to work or provide care to others), of elderly persons declines with age. This results in older persons engaging in unequal social exchanges within the family and being dependent on others to meet their basic needs.

An alternative explanation for the gender difference in the effect of physical health status on the risk of elder abuse is the higher rate of morbidity in women. Older women are more likely to have a poor self-rated health status and limitations in activities of daily living than were older men. This may increase the risk of elder abuse in women.

The relationship with adult children is the most important risk factor in both older men and women. In several studies, family disharmony and a poor or conflicting relationship with

family members have been reported as risk factors for elder abuse. However, few studies have addressed the relationship with adult children, likely due to cultural differences in the living arrangements of older adults in Western countries. Unlike in Western countries, in which older adults living with their adult children is uncommon, in East Asian countries co-residence with adult children is a desirable or preferred living arrangement. Moreover, adult children have an obligation to provide care and financial support to their aged parents. This is in line with other study reports that adult sons- and daughters-in-law are the primary perpetrators of elder abuse, compared to the spouse/partner. [14, Rank 3]

CHALLENGES IN IDENTIFYING INTIMATE PARTNER VIOLENCE (IPV) AMONG OLDER ADULTS

Identifying **intimate partner violence (IPV)** in older adults presents unique challenges, often compounded by societal myths, generational attitudes, and clinical oversights. One key barrier is the **pervasive cultural perception** that older adults, particularly those aged 65 and above, represent a single, uniform group in “late adulthood.” This generalization often leads healthcare providers and support professionals to **overlook the potential for IPV**, based on the assumption that intimate relationships in older age are either non-existent or inherently nonviolent.

However, as longevity and health span increase, it is now evident that older adulthood includes **distinct age-related stages**—each associated with varying relational dynamics and risks for abuse:

- **Ages 60–80:**

Many couples remain **sexually active**, and forced or unwanted sexual activity in this age group may result in **physical trauma** due to age-related changes in reproductive tissues. Additionally, **early cognitive decline** may lead to inappropriate or coercive sexual behaviours from a long-term partner, particularly if consent capacity is compromised.

- **Ages 80 and above:**

At this stage, one or both partners may become **physically frail**, experience **advanced cognitive impairment**, or have experienced **spousal loss**. In some relationships, persistent **demands for sex, coercion, or physically abusive sexual encounters** may occur in the context of dementia-related disinhibition or longstanding abusive dynamics.

- **Reversal of roles:**

In certain cases, **older women who have endured chronic IPV** may become **aggressive or abusive toward a now-frail male partner**, highlighting the shifting dynamics of dependency and control in late life.

These nuances emphasize the **need for age- and context-sensitive IPV screening**. Clinicians must be educated to recognize that IPV can persist or even emerge in later life, and that older adults are not immune to the complexities of abuse. A thorough understanding of the changing physical, emotional, and relational landscape of aging is essential for timely and accurate identification of IPV in this vulnerable population. [4, Rank 3]

SCREENING FOR INTIMATE PARTNER VIOLENCE IN OLDER ADULTS

Screening for **intimate partner violence (IPV)** among older adults remains a complex and **controversial issue**. While IPV is widely recognized as a **significant public health concern**, current recommendations regarding universal screening in the elderly are inconsistent due to **limited and inconclusive evidence**.

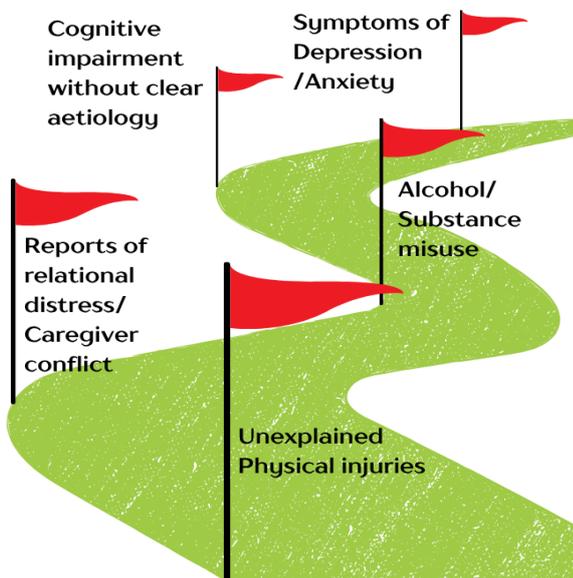
The **U.S. Preventive Services Task Force (USPSTF)** has concluded that there is **insufficient evidence** to assess the **balance of benefits and harms** of routinely screening **all older or vulnerable adults**—including those with physical or cognitive impairments—for abuse and neglect. This cautious stance is based on concerns related to the **sensitivity, specificity, and overall validity of available screening tools**, as well as the **potential**

psychological or social harm that could arise from false positives, stigma, or inappropriate intervention.

Despite these limitations, several leading professional organizations—including the American College of Emergency Physicians, American Academy of Family Physicians, and Emergency Nurses Association—have issued position statements advocating for universal IPV screening for women of reproductive age. However, extending these recommendations to older women remains debated, largely due to a paucity of age-appropriate, validated tools, and the under-recognition of IPV in later life.

For clinicians and healthcare providers caring for older adults, a targeted and contextual approach is encouraged.

Screening for IPV should be considered when clinical indicators or red flags are present, such as



Additionally, the method of data collection plays a crucial role in effective IPV screening. Traditional paper-and-pencil tools may be less effective among older adults, especially those with low literacy levels or limited English proficiency. Emerging technologies, such as Audio Computer-Assisted Self-Interviewing (A-CASI) and tablet-based surveys, offer greater privacy, adaptability, and enhanced user accessibility, and may improve disclosure rates, particularly in sensitive topics like IPV.

To improve identification and intervention, there is an urgent need for:

- Development of culturally sensitive, age-appropriate screening tools
- Routine training for healthcare professionals on IPV in older adults
- Clear referral pathways and multidisciplinary collaboration

Until more conclusive evidence emerges, a balanced, patient-centered approach that emphasizes clinical judgment, cultural competence, and ongoing provider education remains the most effective strategy for recognizing and addressing IPV in older populations.

ADVERSE HEALTH OUTCOMES ASSOCIATED WITH ELDER ABUSE



US \$5.3 billion
Each year in medical costs from violent injuries to older people

Elder abuse has far-reaching consequences that extend beyond the immediate harm inflicted, posing significant risks to both physical and mental health. Victims of elder abuse commonly experience **emotional distress**, including **depression, anxiety, social withdrawal**, and a deepened sense of **isolation**. Financial exploitation often results in the **loss of resources necessary for adequate self-care**, exacerbating their vulnerability.

Physically, elder abuse may result in **acute injuries** such as bruises, fractures, or even **sexually transmitted infections** in cases involving sexual assault. Over time, abuse contributes to the development or worsening of **chronic health conditions**, including **musculoskeletal pain, gastrointestinal issues, respiratory problems, and functional decline**.

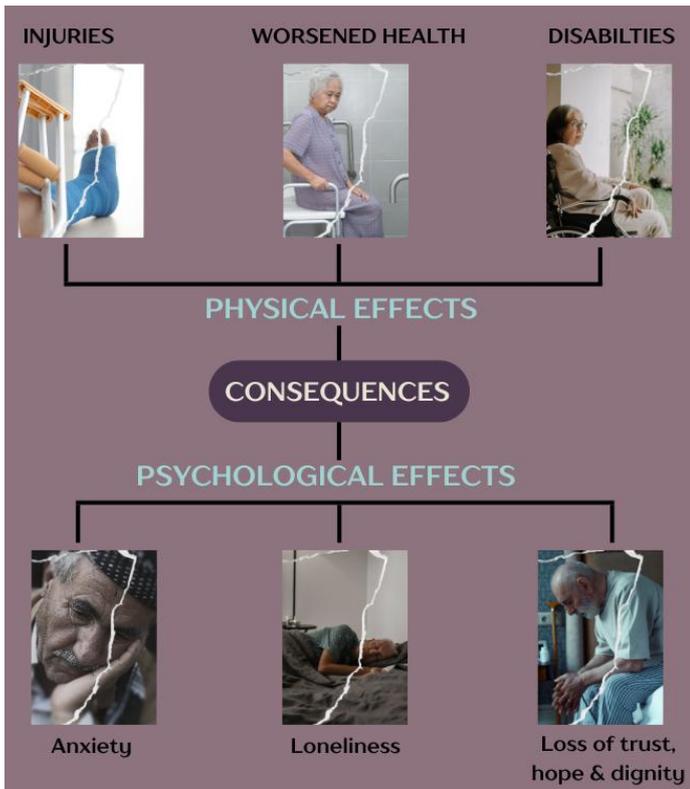
Psychologically, abused older adults exhibit **higher rates of depression, anxiety, and post-traumatic stress disorder (PTSD)** compared to their non-abused counterparts. These mental health consequences may persist long after the abuse has ceased, significantly impairing quality of life and cognitive functioning.

In terms of healthcare utilization, elder abuse is associated with a marked increase in **emergency department visits, hospital admissions, and nursing home placements**.

Abused individuals are more likely to enter long-term care earlier and with greater medical and psychosocial complexity.

Alarming, elder abuse has also been linked to **premature mortality**. Studies indicate that older adults subjected to abuse are at significantly higher risk of **early death**, even after controlling for other health and demographic factors.

In sum, elder abuse is not only a violation of human rights and dignity but a **major contributor to morbidity and mortality** among older adults. Recognition and timely intervention are critical to preventing these adverse outcomes and improving the overall health and well-being of this vulnerable population.



MORBIDITY AND MORTALITY RATES ASSOCIATED WITH ELDER ABUSE

Elder abuse is not only a profound violation of dignity and human rights, but also a significant public health issue with substantial **morbidity and a notably elevated risk of mortality**, even in the absence of overt physical injury. While specific acts of violence or neglect may lead to direct harm, research increasingly shows that **the cumulative stress, psychological trauma, and systemic neglect** associated with abuse can result in **chronic illness, functional decline, and premature death**.

Physicians and other healthcare professionals who work with older adults must remain vigilant and sensitive to elder abuse—also

referred to as **mistreatment of older adults** or **abuse of seniors**—as it often occurs within **trusted relationships**, such as those involving family members, informal caregivers, or institutional staff. These relationships may involve legal, familial, contractual, or even voluntary caregiving responsibilities, which creates a **power imbalance** that increases the risk for abuse and makes detection more complex.

Unlike random acts of violence perpetrated by strangers, elder abuse typically arises **within a context of trust**, and often involves **repeated acts of omission or commission** that result in **physical, emotional, financial, or psychological harm**. While some cases stem from ignorance or inadequate training, elder abuse is considered **non-accidental and intentional**.

Notably, the mortality risk among abused older adults is significantly higher. Longitudinal studies have demonstrated that victims of elder abuse have a **2- to 3-fold increased risk of death** compared to non-abused individuals, even after controlling for comorbidities and sociodemographic factors. This increased risk is believed to result from **compounded effects of psychological stress, untreated medical conditions, poor nutrition, and social isolation**, all of which erode physical and mental resilience.

In some cultural contexts, the term “elder” may not refer strictly to older individuals, but rather

to **community leaders or persons of influence**, irrespective of age. However, in clinical and legal discourse, **elder abuse is specifically concerned with the mistreatment of older adults**, often those who are vulnerable due to age-related decline in cognitive, emotional, or physical functioning.

THE OUTCOMES ASSOCIATED WITH ELDER ABUSE

Despite major gaps in current knowledge, available evidence suggests that elder abuse is associated with significant adverse health outcomes. One study found that self-neglect was associated with an increased risk for all-cause mortality. Similarly, a study of older adults found that self-neglect was associated with a higher mortality rate, particularly during the first year of being identified.

In addition, self-neglect is associated with 15 times increased risk for cancer-related mortality and 10 times increase in nutritional- and endocrine-related mortality. Moreover, research suggests that self-neglecting black older adults had substantially higher all-cause mortality risk, compared with white older adults, and this mortality differential is sustained over time.

Previous studies have shown that elder abuse is associated with psychosocial distress. Abused older adults were more likely to report higher level of depression, anxiety, and posttraumatic

stress disorder. The level of psychological distress differs by the frequency and types of abuse and violence. In addition, older women experiencing psychological abuse repeatedly or multiple types of elder abuse were more likely to present depression or anxiety). Emotional abuse is also significantly associated with higher levels of psychological distress than physical abuse.

Evidence suggests that elder abuse is associated with emergency room visits, hospitalization, and nursing home placement and premature mortality. A study found that that older adult who self-neglect use emergency services three times greater rate than those without self-neglect. In addition, self-neglect is associated with increased rate of hospitalization and longer length of hospital. Moreover, recent study suggests that self-neglect or uses hospice services more frequently and that they have a shorter time between admission and death [21, Rank 5]

IDENTIFICATION OF ELDER ABUSE

The identification of elder abuse relies heavily on either self-disclosure by the victim or recognition by individuals who are in regular contact with older adults and are positioned to detect signs of mistreatment. These individuals may include bank employees, law enforcement personnel, home care aides, legal professionals

(such as lawyers and notaries), nurses, social workers, psychologists, and physicians. Each professional group brings a unique lens to the issue, influenced by the nature of their relationship with the older adult and the context of their interactions.

Among healthcare providers, family physicians play a critical role in identifying elder abuse. Given their continuity of care and established rapport with patients, they are uniquely situated to observe physical indicators, behavioural changes, or inconsistencies in caregiver interactions that may raise suspicion of abuse. On average, family physicians see individual patients four to five times annually, offering repeated opportunities to notice evolving patterns or subtle signs of distress.

Despite their advantageous position, research indicates that physician reporting rates of elder abuse remain among the lowest across healthcare and social service professions. This underreporting may stem from a lack of training, uncertainty about how to proceed, fear of damaging patient relationships, or limited awareness of reporting obligations and legal protections.

Improving detection rates requires enhanced education and training, implementation of standardized screening tools, and the fostering of interdisciplinary collaboration among all professionals involved in the care and support of older adults. [6, Rank 4]

THE RISK OF ELDER ABUSE IN VULNERABLE POPULATIONS

Vulnerability—characterized by financial, physical, or emotional dependence on others, or a diminished capacity for self-care and self-protection—significantly increases the risk of elder mistreatment. Older adults who rely on others for assistance with daily activities or who are perceived as difficult to care for are more likely to be targets of abuse. These vulnerabilities may be compounded by personal, medical, or environmental factors that impair autonomy or communication, limiting the individual's ability to report or escape abuse.

Key domains of vulnerability associated with increased risk of elder abuse include:

1. Impaired Physical Function:

Older adults with physical limitations—such as those resulting from osteoarthritis, stroke, or other chronic conditions—may be dependent on caregivers for assistance with Activities of Daily Living (ADLs) (e.g., bathing, dressing, toileting) and Instrumental Activities of Daily Living (IADLs) (e.g., managing finances, medication, transportation). This dependence may place them at greater risk for neglect or physical abuse, particularly when caregivers are untrained, overwhelmed, or resentful.

2. Cognitive Impairment:

Cognitive decline, including dementia, mild cognitive impairment, or intellectual disabilities, can compromise decision-making, memory, and executive functioning. These impairments not only make caregiving more complex but also expose older adults to financial exploitation and psychological abuse, as they may struggle to recognize abusive behaviors or protect their interests.

3. Emotional Distress or Mental Illness:

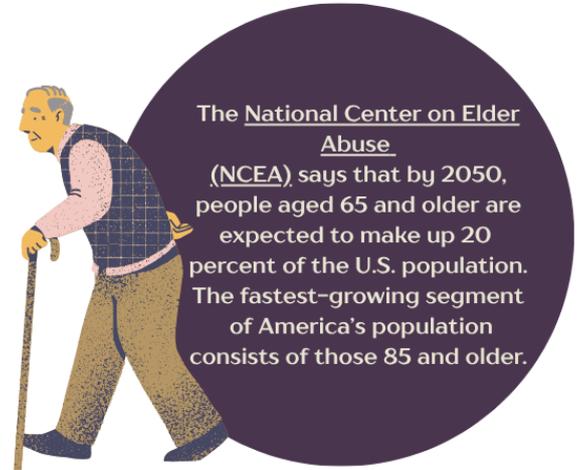
Older individuals experiencing depression, anxiety, or personality disorders may exhibit behaviors that challenge caregivers, such as increased emotional dependence or social withdrawal. In some cases, mental illness may lead to strained relationships, increasing the likelihood of psychological or emotional abuse. Additionally, such vulnerabilities may be manipulated by abusers to maintain control or instill fear.

Highest number and proportion of people age **65** and older in U.S. history. The **40.3** million people ages **65 and older** represented **13%** of the total population



Collectively, these risk factors underscore the importance of early identification, comprehensive assessment, and supportive interventions tailored to the unique needs of

vulnerable older adults. Interdisciplinary collaboration among healthcare professionals, social workers, legal advisors, and caregivers is essential to prevent abuse and protect the rights and dignity of this population.



THE TRUSTED OTHER AND ELDER MISTREATMENT RISK

The term **“trusted other”** encompasses individuals with whom the older adult has a relationship of trust and dependence. This includes **family members, friends, neighbours, paid caregivers, household employees, financial advisors, and other professional or informal advisors**. While these individuals often serve supportive roles, they can also pose significant risk factors for elder mistreatment—especially in situations of stress, dependency, or dysfunctional relationships.

Key Risk Domains Related to the Trusted Other:

1. Dependency on the Elder:

A “trusted other” may be **financially or emotionally dependent** on the older adult, potentially fostering **resentment, manipulation, or exploitation**. Financial dependence may motivate individuals to maintain **unwanted or exploitative relationships**, while emotional dependence can create **conflicted dynamics** that increase the risk of neglect or emotional abuse.

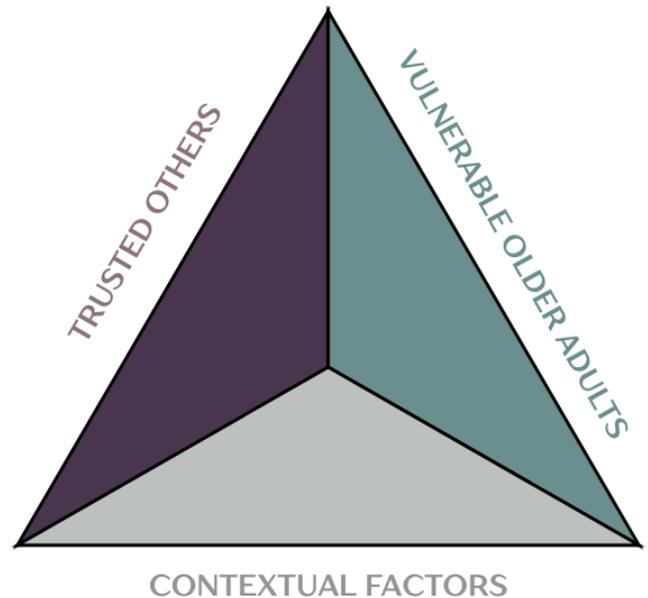
2. Emotional Distress or Mental Illness:

Caregivers or trusted individuals experiencing **depression, anxiety, substance misuse, or personality disorders** (e.g., hostility, narcissism) may have **diminished capacity to provide safe and compassionate care**. High stress or unaddressed mental health challenges can lead to **impulsive or abusive behaviors**, particularly in unmonitored or isolated care environments.

3. Impaired Physical Function of the Caregiver

When a trusted other is themselves **physically impaired** (e.g., due to osteoarthritis or other chronic illness), their **ability to provide adequate care** may be compromised. This can unintentionally lead to **neglect or insufficient support**, especially when caregiving demands are high.

CONTEXTUAL FACTORS AFFECTING THE ELDER–TRUSTED OTHER RELATIONSHIP:



Understanding the interplay between trusted others, the vulnerabilities of older adults, and the contextual environment is crucial to effectively identifying, preventing, and intervening in elder mistreatment. Tailored assessment tools and culturally informed approaches are essential for healthcare and social service professionals working in elder care.

1. Social Isolation:

When both the older adult and trusted other are **disconnected from broader social networks or formal support systems**, the **risk of undetected mistreatment increases**. Isolation limits the presence of **external observers**, and in some cases, the trusted other may deliberately **restrict the elder’s contact with others**, further exacerbating the potential for abuse.

2. Low-Quality Relationships:

The nature of the relationship—often established **prior to caregiving responsibilities**—can play a pivotal role in determining the caregiving environment. **Positive, supportive relationships** may protect against mistreatment, while **dysfunctional or conflict-laden histories** can increase the likelihood of **abuse, neglect, or exploitation**.

3. Cultural Norms and Generational Beliefs:

Cultural and generational attitudes significantly influence perceptions and responses to elder mistreatment. For example:

- In some cultures, illnesses like **Alzheimer's disease are stigmatized**, prompting secrecy and **isolation of both the elder and caregiver**.
- Cultural norms of **self-reliance** may discourage caregivers from **seeking external help**, even when overwhelmed.
- Older adults from certain generations may be less likely to report abuse, especially when influenced by norms of **respect for authority** or **taboos surrounding family conflict** or **intimate partner violence**.

PERSPECTIVES ON ELDER ABUSE BY HEALTHCARE PROFESSIONALS

A recent national study found one in ten persons 60 years and older, reported emotional, physical, or sexual mistreatment or potential neglect in the past year. It is difficult for persons who are older to report mistreatment. Victims have many reasons for not reporting elder mistreatment, including fear of retaliation, being afraid of institutionalization, being ashamed, lack of information on who to contact for reporting, and thinking no one can help

In the critical care setting, patients are treated for brief but severe episodes of illness, and the intensity of the situation may not allow for exploration or thoughts of elder abuse. Barriers for healthcare providers in the critical care setting for reporting elder abuse are varied and include the patient as potential victim, patient's family/significant others, and the healthcare provider. High patient acuity and lack of consciousness are important factors that hinder reporting of abuse by the patient and when alert and responsive, the typical barriers exist, i.e., fear of retaliation, fear of being placed in a nursing home, powerlessness, and wanting to protect their family. Family members may know or actually be the perpetrators and they deny the abuse. For the healthcare provider, reporting barriers may be lack of knowledge about the law, not wanting to be involved in

court cases, and not routinely screening for abuse

While laws require reporting regardless of mitigating circumstances, most healthcare professionals consider the broader context of the patient before reporting, including patient autonomy and rights, patient-physician confidentiality, quality of life, and future patient-healthcare professional relationships. Researchers interviewed a convenience sample of few family and general internal medicine physicians to identify their perspectives on mandated reporting of elder abuse. They reported that physicians worry about future physician-patient rapport and trust, patient quality of life, and physician control when deciding to make an elder abuse report [9, Rank 3]

REGULATORY OBLIGATIONS FOR NURSING PROFESSIONALS ON REPORTING ELDER ABUSE

Various guidelines are suggested for improving nursing practice for elder abuse.

Suggestions include the following:

- Conduct health history in private
- Ask safety questions on admission assessment
- Readdress the issue of elder abuse at discharge from the unit

- Establish the reporting of elder abuse as a priority for the unit
- Offer elder abuse education in addition to that required by law.

Nurses can ask questions, **“On admissions, they can ask questions like, Are you in a relationship where you feel unsafe? Are you in a relationship where you are being harmed by someone? Do you want to harm yourself?”** Those kinds of things. They can ask those questions, and that gives them an opportunity to say, Yes.”

Additional education is suggested by providing information about the seriousness of elder abuse. [10, Rank 3]

Nurses need to continually be aware, to act on their suspicious feelings, and to obtain additional information from the patients or respective family members/significant others who can provide needed information.

Hospital social services could implement a protocol that provides feedback to reporters when they are notified of the decision by adult protective services to accept the report and provide an outcome of the investigation. Having such a mechanism in place would raise awareness of elder abuse and provide the reporter with more confidence that the extra work of investigating was worth the effort.

Hospital employees who report the allegation of abuse receive the results of adult protective services investigations and should report those

results to the healthcare professionals involved in the collection of relevant information.

Assessment for abuse or risk factors of abuse is acknowledged on admission to a unit; however, this assessment should also occur at discharge from the unit. Persons admitted to critical care are in critical condition and usually not of sound mind to answer questions or provide relevant information, but at discharge their health has improved and useful information may be obtained.

IDENTIFYING PHYSICAL ABUSE IN ELDER ABUSE

Elder abuse puts older adults at risk of life-threatening injuries. Victims of elder abuse are four times as likely to be admitted to a nursing home and three times as likely to be admitted to a hospital. Approximately one in 10 older adults in the United States has experienced some form of abuse, although prevalence estimates tend to be conservative because many cases of elder abuse go unreported.

One reason for underreporting is that it is difficult to recognize and identify. In one study of older adults receiving in-home nursing visits, it took an average of 10.5 visits for a nurse to determine that abuse was occurring. Healthcare professionals are uniquely situated to detect clinical manifestations of abuse, but the diagnostic coding for possible elder abuse is rarely documented in medical records. Despite the seriousness of the problem, research on

elder abuse lags behind that of child abuse and intimate partner violence, especially with regard to identifying specific injury patterns or forensic markers that raise suspicion of abuse. Physical abuse and neglect may lead to injury patterns that differ from those related to accidents. A study on bruising patterns found that the location of bruises on the body in abused elderly adults was similar to those in situations of intimate partner violence. Fractures are considered to be a potential sign of interpersonal violence and child abuse, but there has been little research examining signs of elder abuse in individuals with fractures.

A number of aging-related conditions such as osteoporosis and gait instability may predispose older adults to fractures. Fractures in older adults are not unusual, but their cause can be difficult to determine: “It is important to be aware that although accidents are a legitimate cause of injury for older adults with cognitive impairments, not all injuries are the result of accidents.” Thus, in older adults with fractures, there may be additional findings that should raise suspicion of abuse. If a fracture is present alongside other forensic markers that correlate with abuse, further investigation may be warranted [11, Rank 5]

There are a number of reasons why elder abuse is hard to detect. When asked, victims are often reluctant to answer for reasons including fear of retaliation, stigma of victimization, fear of

being removed from home, desire to protect the perpetrator, and in some cases involving persons with dementia, difficulty communicating what transpired. The fact that older people often have underlying health problems that may mask markers of abuse and neglect complicates detection on the part of health professionals. In most cases of abuse and neglect, the evidence is often not readily available or clearly indicative, falling into a Gray area of subtle indicators. Although each forensic marker observed individually may mimic physiological age-related conditions, diseases, or injuries, these markers may be red flags for abuse when considered cumulatively.

Elder abuse, defined as intentional harm or failure to meet an elder’s basic needs or protect them from harm, is a serious human rights violation and an escalating public health concern linked to increased morbidity, mortality, and adverse mental and physical outcomes. As global populations age, especially in community settings, preventing elder abuse becomes increasingly critical. Despite wide variability in prevalence estimates—due largely to inconsistent definitions, cultural influences, and methodological limitations—certain risk factors are consistently noted, including advanced age, female gender, lower socioeconomic status, marital status, and poor health. Gender, in particular, plays a significant role, with older women—especially in non-Western societies—more frequently subjected to abuse. While Western countries report similar abuse rates across genders, underlying gender-specific roles and societal expectations may influence both the experience and reporting of abuse. Dependency, often a precursor to abuse due to caregiver burden, may also be gendered, shaped by cultural norms and expectations of care. These insights underscore the necessity of gender-sensitive research and interventions that account for sociocultural dynamics to effectively prevent elder abuse in community settings and ensure tailored support for vulnerable populations. [12, Rank 4]



GUIDELINES REGARDING ELDER ABUSE PREVENTION IN COMMUNITY SETTINGS

IDENTIFICATION OF ELDER ABUSE IN EMERGENCY MEDICAL SERVICES

Elder abuse is defined by the Centers for Disease Control and Prevention as “an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.” Types of elder abuse include neglect as well as physical, sexual, emotional/psychological, and financial exploitation. Approximately 10% of older adults in the United States (U.S.) experience elder abuse. Besides the obvious problems of suffering and injustice, elder abuse also frequently results in physical injury, financial loss, and increased use of health care resources. Moreover, individuals who experience elder abuse have reduced life expectancy.

While elder abuse has received increasing attention over the past two decades from patient advocacy groups, government agencies, and public and private funders, challenges with recognition and meaningful interventions remain prevalent. In fact, most cases of elder abuse are not identified or reported by medical providers, county-level service agents, or others positioned to provide protection. Some cases are missed even when older adults present for medical care with physical findings suggestive of elder abuse.

Physical findings that may suggest elder abuse include dirty clothing, poor hygiene, malnutrition, bruising, burns, pressure ulcers, unexplained fractures, depression, anxiety, or impaired function. However, among older adults, many of these physical findings can occur for reasons other than elder abuse, making it difficult to determine etiology based on physical exam. In part as a result of the challenges of interpreting these findings without information about the patient’s living condition and availability of help at home, fewer than 5% of cases are reported to authorities. In contrast, approximately one half of child abuse cases are reported.

Emergency medical service (EMS) providers are uniquely positioned to uncover cases of elder abuse for several reasons.

- **First**, older adults experiencing abuse are twice as likely as other older adults to visit the emergency department, and the ambulance is the mode of arrival for ~38% of all emergency department visits in this population. (Although the exact number of unique older adults cared for by EMS providers each year in the U.S. is not known, extrapolation from state-based data suggests that more than 4 million unique individuals are cared for each year.)
- **Second**, for most responses EMS providers enter the patients’ residence, giving them the opportunity to directly observe the

living situations of the patient including hygiene, safety, mobility supports, access to food, quality of heating and cooling, clutter, expired medications, and other environmental hazards.

- **Third,** EMS providers can observe caregivers' behaviors and interactions with patients. Since EMS responses are almost always unplanned, the EMS response does not give caregivers a chance to tidy up the patient and home or, if intoxicated, sober up.
- **Fourth,** EMS providers often make frequent visits to long-term care environments and may be able to identify patterns of inappropriate care.
- **Finally,** EMS providers are often the only healthcare providers to evaluate older adults that refuse transport, which is up to 10% of older adults in some populations. This encounter provides a unique opportunity for EMS to address social concerns, like elder abuse, that may otherwise be overlooked. The role of prehospital providers in improving the health of older adults has been recognized as a clinical and research priority [15, Rank 4]

Several studies have evaluated EMS providers' attitudes toward elder abuse and establish that, while prehospital providers believe elder abuse is a prevalent and important issue, a lack of EMS protocols and training specific to elder

abuse limits their potential to identify this problem and take appropriate action. EMS protocols, which are established by state or regional EMS medical directors, define the operating procedures for EMS providers to follow.

Although EMS providers can provide care outside of the protocols and also have the ability to contact a medical director for guidance or oversight, for the most part EMS care is constrained by protocols and the training that accompanies these protocols. Thus, EMS providers report that the lack of protocols creates a challenge for them in identifying and reporting cases of elder abuse.

THE IMPACT OF STATE-WISE PROTOCOLS IN ADDRESSING ELDER ABUSE

State-wide EMS protocols for identifying and caring for elder abuse vary in regard to identification, management, and reporting, with most protocols having no content at all on the subject. Only a small subset of the examined protocols describes indicators of elder abuse. Further, among protocols that describe indicators, the content is primarily focused on physical indicators (burns, fractures, bruises) and the timing and nature of the chief complaint (inconsistent or delayed report). While these indicators are important, they are insufficient to provide a robust approach to identify elder abuse.

Physical abuse is less common than other forms of elder abuse such as neglect, and therefore, findings from the physical exam will only capture a small proportion of older adults experiencing abuse. Similarly, chief complaints during emergency care are rarely indicative of abuse, so focusing on them as an indicator is likely to only modestly improve the sensitivity of EMS provider evaluations to identify elder abuse.

Additional indicators that EMS providers might use to identify elder abuse include characteristics of the home environment such as broken utilities, lack of heating or cooling, presence of odors, an empty refrigerator, extreme cluttering, expired medication bottles, safety hazards. Also, consideration of caregiver behavior, or the conspicuous absence of a caregiver, might provide further insights in the presence of elder abuse.

Instructions regarding reporting are also limited in statewide protocols, with only around 6% describing details on what should be reported and nearly 14% describing who should be notified.

When identified, EMS providers should report elder abuse to two groups.

- First, if the case meets state reporting requirements (e.g., the patient has a cognitive or physical disability resulting in dependency on others), a report should be

made to the appropriate county-based social service agency.

- Second, the EMS provider should communicate this concern and the details they observed to the receiving emergency provider. A clear understanding as to whether elder abuse is present often requires multiple observers; by notifying providers in the emergency department, EMS providers can catalyze subsequent observations that may inform consequent interventions to protect patient safety. [16, Rank 4]

ATTITUDES OF EMERGENCY MEDICAL SERVICE PROVIDERS TOWARDS ELDER ABUSE

In contrast to elder abuse, child abuse is mentioned in twice as many statewide EMS protocols, suggesting a greater prioritization for the identification of child abuse than elder abuse in several states. A disparity in the attention given to elder abuse vs. child abuse has also been observed in emergency department-based protocols. Nonetheless, it is a somewhat surprising finding that child abuse protocols are not universal. Additionally, a number of the child abuse protocols have very limited content regarding key issues such as indicators and reporting. Not surprisingly, many of the problems identified by EMS providers as obstacles to elder abuse

identification and reporting have also been reported for child abuse.

Studies assessing EMS attitudes toward elder abuse found that while EMS providers express a desire to identify and report elder abuse, they often feel that they have insufficient guidance regarding how to do so. Several studies are consistent with this perspective and suggests the need for (1) more substantial protocols regarding elder abuse identification and intervention, (2) clearer instructions regarding when these protocols should be implemented, (3) dissemination of these protocols throughout the country, and (4) more structured reporting guidelines and mechanisms

In almost all states with state-wide protocols, non-EMS leadership can provide suggestions for protocols, which are usually updated every 5-years. However, at present, a primary limitation of knowledge translation regarding detection and management of elder abuse in the prehospital setting is a lack of primary research in this area. There are no validated tools for EMS to screen for elder abuse. Further, the public health value of screening for elder abuse, although readily apparent to most experts, has not been established in any setting. Consistent with this limitation, the U.S. Preventive Services Task Force concluded in their recommendation on elder abuse screening that there is insufficient evidence to assess the balance for benefits and harms.

Considering the unique position EMS providers have to identify geriatric issues beyond elder abuse, improvements and dissemination of EMS protocols to identify elder abuse might overlap with efforts to identify older adults in need of additional support, such as a referral to a social worker or food assistance program. In fact, recent efforts have expanded the roles of EMS providers and other first responders to allow for the provision of routine healthcare services, such as healthcare screening and promotion programs. Given the high prevalence and substantial morbidity of elder abuse, elder abuse screening is an important additional focus for these EMS-led community programs. [17, Rank 5]

THE ROLE OF HEALTHCARE PROFESSIONALS IN IDENTIFYING ELDER ABUSE

Paramedics can identify older adults at risk of elder abuse, implementing screening protocols for EMS providers may effectively leverage the unique position of these providers to identify and report cases of elder abuse. Due to large number of older adults transported and limited time of EMS providers to conduct a screen, an optimal approach to elder abuse screening may be a multi-tier screen in which a simple, brief, but fairly sensitive initial set of observations are used to identify patients who might be at risk, and additional assessment by EMS providers or

by ED nurses and physicians is made of this high-risk subset of patients.

Further, given the complexity of identifying elder abuse and the importance EMS provider judgement plays when determining how to treat a patient, a semi-structured protocol that relies on the subjective judgement of EMS providers may yield a more accurate screening tool than a highly structured approach. The addition of elder abuse screening to EMS protocols would need to be accompanied by training of EMS providers.

The National Association of Emergency Medical Technicians' Geriatric Education for EMS (GEMS) course includes content on elder abuse screening and provides one such training opportunity. Additional studies are needed to develop and test instruments that efficiently and accurately leverage the unique position of EMS providers to identify elder abuse in the prehospital setting. Even in the absence of these protocols, it is likely that EMS providers identify concerns for a substantial portion of older adults they evaluate. Emergency providers and admitting physicians can help their patients by being receptive to the observations of EMS providers and should attempt to obtain clinical information directly from EMS providers whenever possible.

State-wide EMS protocols for elder abuse vary in regard to identification, management, and reporting, with most states having no content at all on this subject. Expansion and

standardization of existing protocols and dissemination to other states may increase the identification of elder abuse in the prehospital setting. Further research is needed to define the optimal approach for prehospital elder abuse screening and, more broadly, develop and test EMS protocols that identify social and non-medical problems among older adults and link patients with needs to local social services. [18, Rank 4]

MANAGEMENT PRINCIPLES TO ADDRESS ELDER ABUSE

Although there is no universally accepted framework for managing elder abuse, healthcare professionals play a critical role in screening, reporting, intervention, and prevention. Addressing elder abuse requires navigating complex ethical and legal considerations, with **decision-making capacity** serving as a cornerstone for evaluating each case. Effective management is best achieved through **interdisciplinary collaboration** among healthcare providers, social service agencies, and legal professionals.

Role of Healthcare Professionals

Healthcare providers are uniquely positioned to screen for elder abuse, particularly during routine clinical encounters. Questions about daily functioning, caregiver support, and living conditions can uncover vulnerabilities or risk

factors for abuse. Functional and cognitive assessments offer important insights into predisposing or precipitating factors that compromise an older adult's independence.

Psychosocial distress—manifesting as anxiety, depression, or withdrawal—may also signal abuse or neglect and warrants further investigation.

Given the frequent interaction between victims of elder abuse and the healthcare system, **emergency departments and hospital settings** serve as crucial touchpoints for screening. **Discharge planning and home health services** can identify unsafe environments and offer opportunities for intervention. Early detection and proactive support—such as treatment of medical or psychiatric conditions, community-based services, and family engagement—can help mitigate or prevent elder abuse.

Suspicion of abuse should prompt reports to:

- **Adult Protective Services (APS)** for cases in the community, and/or
- **Long-term care ombudsman agencies** for incidents in licensed facilities.

Reporting Requirements and Challenges

Nearly all U.S. states have **mandatory reporting laws** requiring healthcare professionals to report **reasonable suspicions of elder abuse**. APS investigates alleged mistreatment in the community, while

ombudsman agencies address concerns within licensed care facilities.

Despite these mandates, **physicians are often rated among the least helpful** in identifying and reporting abuse. Commonly cited barriers include:

- Subtle or ambiguous signs
- Victim denial or minimization
- Unfamiliarity with reporting procedures
- Fear of damaging the physician-patient relationship
- Concerns about the effectiveness of APS intervention
- Ethical tensions between **mandatory reporting** and **respect for patient autonomy**

APS agencies vary in the services they provide due to differences in state laws, funding, and interpretation of statutes. Nonetheless, APS interventions are grounded in principles of **autonomy, least restrictive care, and preservation of family units** when appropriate. APS professionals presume capacity unless a healthcare provider or court determines otherwise.

Decision-Making Capacity

A critical question in elder abuse cases is: **When should healthcare professionals override a person's wishes to ensure their safety?** This decision hinges on **assessing decision-**

making capacity—a task routinely conducted by clinicians.

Capacity is not binary; rather, it exists along a spectrum. Complex decisions (e.g., refusing life-saving care) require a higher threshold of cognitive functioning, whereas simple decisions may be within the capacity of a cognitively impaired individual. Clinicians often must translate this **gray area** into **clear, actionable determinations**, especially when initiating guardianship or protective interventions.

Brief tools like the **Mini-Mental State Examination (MMSE)** are insufficient in most cases. More targeted tools—such as the **Hopkins Competency Assessment Test**—are more appropriate for capacity evaluations in elder abuse cases.

Interdisciplinary Team Approach

Given the multifactorial nature of elder abuse, **interdisciplinary teams** are increasingly used to coordinate care and intervention. These teams often include:

- Primary care providers
- Social workers
- Legal advisors
- Mental health professionals
- Ethicists
- Law enforcement
- Community advocates
- Public health officials

In-home assessments prior to team meetings are highly valuable in providing contextual information. According to surveys of APS workers, these teams are instrumental in:

- Confirming abuse
- Documenting impaired capacity
- Reviewing medications and health conditions
- Facilitating guardianship/conservatorship
- Persuading clients or families to take protective action
- Supporting law enforcement involvement

While further research is needed to assess their cost-effectiveness, **interdisciplinary teams are widely perceived as a practical and impactful strategy** in managing elder mistreatment.

PREVENTION STRATEGIES FOR ELDER ABUSE: A NURSING PERSPECTIVE

Nurses, as frontline healthcare providers, are uniquely positioned to implement **preventive strategies** to reduce the risk of elder abuse. Through regular patient interactions, home visits, discharge planning, and community outreach, nurses can proactively assess risk factors, educate patients and caregivers, and advocate for protective interventions.

1. Risk Assessment and Early Identification

- **Routine Screening:** Incorporate validated elder abuse screening tools (e.g., Elder Abuse Suspicion Index [EASI], Hwalek-Sengstock Elder Abuse Screening Test) into nursing assessments.
- **Holistic Evaluations:** Assess not only physical health but also psychosocial, environmental, cognitive, and functional status.
- **Identify Red Flags:**
 - Frequent unexplained injuries
 - Poor hygiene or signs of neglect
 - Malnutrition or dehydration
 - Inconsistent or delayed care-seeking
 - Sudden changes in financial situation

2. Patient and Caregiver Education

- **Empower Older Adults:** Educate them about their rights, signs of abuse, and how to seek help safely and confidentially.
- **Support Caregivers:** Provide information on caregiver stress, burnout prevention, and available support services to reduce the risk of unintentional neglect or abuse.
- **Promote Self-Advocacy:** Encourage older adults to participate in decisions about their care, finances, and living arrangements.

3. Environmental and Home Safety Assessments

- Conduct **home visits** (especially in community health and geriatric nursing) to evaluate:
 - Cleanliness and hygiene
 - Food availability
 - Medication safety
 - Presence of hazards (e.g., tripping, broken utilities)
 - Signs of social isolation or abandonment
- Advocate for **home modifications** and in-home support services to enhance safety and independence.

4. Strengthening Support Networks

- Identify and **mobilize social support systems**, including family, neighbours, senior centres, churches, and volunteer organizations.
- Refer to **adult day programs**, meal delivery services, respite care, and mental health counselling.
- Collaborate with **social workers** and **case managers** to develop individualized care plans.

5. Cognitive and Mental Health Monitoring

- Monitor for **depression, dementia, and anxiety**, which are both risk factors and consequences of abuse.
- Address substance use, behavioral changes, or signs of emotional withdrawal.

- Refer patients for cognitive testing when decision-making capacity is unclear or deteriorating.

6. Advocacy and Mandatory Reporting

- Understand and follow **mandatory reporting laws** in your state.
- Report suspected abuse promptly to:
 - **Adult Protective Services (APS)**
 - **Long-Term Care Ombudsman** (for institutional abuse)
 - **Law enforcement**, when appropriate
- Document observations clearly, objectively, and thoroughly in the patient's medical record.

7. Policy Development and Community Engagement

- Participate in **interdisciplinary elder abuse prevention teams**.
- Engage in **community outreach and education programs** focused on elder rights, healthy aging, and caregiver support.

Advocate for **healthcare policies** that support elder abuse prevention, such as better staffing in long-term care facilities and funding for APS.

THE SCOPE OF ELDER ABUSE

Elder abuse, also called elder mistreatment or elder maltreatment, includes psychological, physical, and sexual abuse, neglect (caregiver

neglect and self-neglect), and financial exploitation. Evidence suggests that 1 out of 10 older adults experiences some form of elder abuse, and only a fraction of cases are actually reported to social services agencies. At the same time, elder abuse is independently associated with significant morbidity and premature mortality. Despite these findings, there is a great paucity in research, practice, and policy dealing with this pervasive issue.

Several agencies strive to take measures to prevent elder abuse. A few names to mention would be:

National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Administration on Community Living (ACL), Department of Justice Civic Division, National Institute of Justice, Office of Victims of Crimes and the Office on Violence Against Women etc.

Despite the services provided by these federal agencies, many older adults continue to experience abuse, neglect, and exploitation.

According to the World Health Organization, the prevalence of elder abuse ranged widely from 1% to 35%, depending on the populations, settings, definitions, and research methods. Recent national estimates show that at least 1 in 10 older adults suffers some form of elder abuse, and many in repeated forms. At the same time, only a small fraction of elder abuse is reported to the Adult Protective Services (APS). The U.S. National Elder

Mistreatment Study, conducted with a representative sample of adults aged 60 years and older, reports that approximately more than 10% of community-dwelling elderly adults experienced abuse or potential neglect every year.

Elder self-neglect is often thought as a separate entity as opposed to elder abuse perpetrated by others. Data from Adult Protective Services (APS) suggest that self-neglect is on the rise and is more common than all of the other forms of elder abuse combined. Recent studies in a large-population-based study indicate that prevalence of elder self-neglect is about 9%, although the extent of overlap between self-neglect and other forms of elder abuse is unclear.

Despite the increasingly diverse aging population, we have little knowledge on the racial/ethnic differences on the issues of elder abuse. Evidence suggests that prevalence of financial exploitation is almost three times higher and psychological abuse is two times higher in African American older adults than white older adults

Understanding cultural-specific issues on the definitions, perceptions, and factors associated with elder abuse will be critical to the future design of prevention and intervention strategies in the cultural-specific context. [19, Rank 3]

UNDERSTANDING THE CHARACTERISTICS ASSOCIATED WITH ELDER ABUSE

Sociodemographic Characteristics

Previous research has documented inconsistent results on the possible association between sociodemographic characteristics and the occurrence of elder abuse. A survey with community-dwelling caregivers reports that younger irrational patients have a higher possibility of suffering from verbal abuse. In contrast, other studies have not found any difference in terms of age and sex between elder abuse victims and nonvictims. Different research methodology and population settings may account for the inconsistency of findings. Available evidence suggests that those older than 75 years, African Americans, and those with lower socioeconomic status are associated with elder abuse.

Physical and Cognitive Function

At the individual level, cognitive and physical function impairment are also associated with increased risk for elder abuse. In a population-based study of community-dwelling older adults with elder abuse experience, it was found that lower global cognitive function level, Mini-Mental State Examination (MMSE), episodic memory, and perceptual speeds are associated with increased risks of elder abuse. Several

cross-sectional studies have found that cognitive impairment and physical disability are associated with increased risk for self-neglect, even after considering sociodemographic and socioeconomic status.

Few longitudinal studies have examined the factors associated with self-neglect. One study of older adults in the Established Populations for Epidemiologic Studies of the Elderly (EPESE) found that greater cognitive impairment and depressive symptoms predict self-neglect reports to APS. Another study of older adults demonstrated that decline in physical function (both observed physical performance testing and self-reported) and executive function is also associated with elder abuse

At the family level, certain caregiver–care recipient characteristics have been associated with elder abuse. Caregivers for demented patients with lower levels of physical functioning are more likely to report engaging in abuse. Agitation and aggression are among the most common and problematic symptoms occurring with dementia. More than half of the demented patients exhibit occasional aggressive behaviors. Another study with a convenience sample of caregiver–care recipient community also reveals that patients who direct the physical assault and aggression behaviors toward their caregivers are more likely to be victimized by elder abuse [20, Rank 2]

Psychosocial Wellbeing

In recent years, research studies and clinical cases have started to document the associations between elder abuse and psychosocial distress. Older adults with depression and signs of anxiety had higher risks of elder abuse. In a study, it was found that depression was significantly associated with elder abuse cases reported to APS. Loneliness was associated with increased risk of elder abuse. In addition, the association between psychosocial distress and elder abuse was affected by sociodemographic characteristics. Another study found that among older adults with depressive distress, those who were older and had lower education levels may have increased risk of elder abuse. Demented female patients were reported to be more likely to have a higher risk of experiencing neglect. Recent studies suggest that older adults with higher levels of psychological distress and lower levels of social relations are more likely to be reported to APS.

FUTURE DIRECTIONS

For psychological well-being, it is critical to explore the impact of psychological decline on the risk for elder abuse, as well as the impact of elder abuse on psychological distress and trajectories. Comprehensive assessment of psychological factors is needed on the constructs of depression, anxiety, perceived stress, hopelessness, suicidal ideation, and other clinical psychiatric constructs. For social

well-being, research is needed to examine the temporal relations between social network, social support, loneliness, and social participation in relations to elder abuse. Social network analyses will be important tools to elucidate the network size, density, and quality in relation to the risk for elder abuse.

Longitudinal research is also needed to understand the potential perpetrators' characteristics, relations, settings, and contexts with respect to elder abuse victims. The fields of child abuse and domestic violence have demonstrated feasibility of conducting research on potential perpetrator(s), and we need to continue pushing for innovative methods to understand the potential perpetrators' perspectives. This data will have direct relevance on the design and conduct of prevention and intervention studies.

Research is needed to understand the consequences associated with specific subtypes of elder abuse. Research is needed to explore the risk, rate, and intensity of these health services utilizations with respect to elder abuse. Economic analyses are needed to examine the costs associated with elder abuse, specific subtypes, and intervention programs. As many cost–benefit analyses are biased toward older adults, innovative strategies are needed to capture the wide range of personal, community, financial, and societal costs of elder abuse. [24, Rank 5]

CONCLUSION

Elder abuse is now recognized internationally as an extensive and serious problem, urgently requiring the attention of health care systems, social welfare agencies, policymakers, and the general public. Reports from the World Health Organization, United Nations, and other international bodies have prominently featured elder abuse and highlighted the range of harmful activities subsumed under this rubric throughout the world. With a global explosion in the older adult population, elder abuse is expected to become an even more pressing problem, affecting millions of individuals worldwide. Elder abuse is associated with devastating individual consequences and societal costs, meriting attention as a serious public health issue.

Elder abuse is likely the most widespread problem of older people that is largely preventable (unlike many disease conditions of old age). Therefore, a better understanding of causes and prevention of elder abuse should be a major international priority. Fortunately, an improving international scientific literature has accompanied this growing concern, including prevalence studies in a number of countries and international comparative projects. In addition, prevention strategies have been increasingly documented [25, Rank 5]

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