Elder Mistreatment: Implications for Public Health Dentistry

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Abstract

Elder mistreatment has increasingly been recognized as a serious and complex health issue affecting large numbers of elders each year. Health professionals have been found to lack knowledge regarding assessment, diagnosis, intervention, and reporting criteria of this problem. In dentistry, there have been recent calls for more research and publications as well as requests for professional policy statements and guidelines. Public health dentistry, with its emphasis on prevention, can lend guidance and leadership at the primary, secondary, and tertiary levels. This article reviews the types and prevalence of elder mistreatment, discusses predisposing variables, and offers an ecological model that serves as a guide to interventions directed at all levels of elder mistreatment prevention. [J Public Health Dent 2001;61(3):131-37]

Key Words: dentistry, elder mistreatment/prevention.

During the last 20 years elder mistreatment has increasingly been recognized as a serious and complex problem with multiple etiologies and manifestations. It often has been described as the last form of family violence to receive attention from practitioners and researchers (1). Although a variety of terms have been used to describe this phenomenon—including battered elder syndrome, maltreatment of the elderly, and elder abuse/neglect (2-8)—the currently recommended framework for organizing the subcategories of this phenomenon is elder mistreatment (9).

Health care professionals still lack knowledge regarding assessment, diagnosis, intervention, outcome, and reporting criteria of elder mistreatment (6,10). This is particularly true of the dental profession. A Medline search that reviewed citations from 1966 to 1997 reported that only 467 publications were cited with a focus on elder mistreatment and of these, only 26 (including editorials) were dental publications (11). Although many professional organizations have issued policy statements, identification guidelines, or required affiliates to have policies and procedures for treatment and reporting of mistreated elders (e.g., American Medical Association, American Nurses Association, American Bar Association, and Joint Commission for Accreditation of Hospitals and Health Care Organizations), organized dentistry has not demonstrated similar efforts (11). Public health dentistry, with its emphasis on prevention and its long history of multidisciplinary collaboration to affect policy change, has the potential to contribute significantly to efforts to reduce the incidence of elder mistreatment. The following review of elder mistreatment types, predisposing variables, and preventive interventions is intended to provide a framework for public health dentistry's involvement and advocacy in this complex problem.

Definition

The federal definitions of elder abuse, neglect, and exploitation, which first appeared in 1987 in the Amendments to the Older Americans Act, were intended to serve only as guidelines for identifying problems and not for enforcement purposes (12). Statutes defining elder mistreatment for enforcement purposes exist in all 50 states; however, there are differences in both their definition and whether they are categorized as elder mistreatment legislation or as part of a more broadly constructed adult protective services legislation (13). The three basic categories of elder mistreatment include domestic elder mistreatment, institutional elder mistreatment, and self-neglect or self-abuse (not addressed in this manuscript). Generally, elder mistreatment is addressed in terms of acts of commission (intentional infliction of harm) or acts of omission (harm occurring through neglect) by a caretaker. Although the definition of a caretaker may vary among states, a typical definition includes "a related or nonrelated person who has the responsibility for the protection, care, or custody of a dependent adult as a result of assuming the responsibility voluntarily, or by contract, through employment, or by order of the court " (Iowa, §235B. 2 (1), 1996).

The literature describes eight types of elder mistreatment (14-18): physical abuse and neglect, sexual abuse, psychological abuse and neglect, financial/ material exploitation, violation of personal rights, and self-neglect (Table 1). Individual cases may exhibit characteristics of multiple types of mistreatment with varying degrees of severity ranging from mild to lethal.

Physical abuse includes the intentional use of physical force resulting in bodily harm, anguish, or pain and includes such acts of violence as striking (with or without an object), hitting, beating, pushing, shaking, slapping, kicking, pinching, burning, inappropriate use of drugs and/or physical restraints, force-feeding, and any other kind of physical punishment. Research has indicated that mistreatment of an elder is seldom an isolated incident, with physical abuse or neglect reoccurring in up to 80 percent of cases (19). In an evaluation of 3,153 emergency department visits where elder physical abuse or neglect was reported, only 1,975 different patients were seen, with 63 percent repre-

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TABLE 1
Types of Elder Mistreatment

Type of Abuse	Definition
Physical abuse	Intentional acts by a caretaker resulting in bodily harm, anguish, and pain; acts that are typically at variance with the history given of them; unreasonable confinement, punishment, or assault; repeated patterns of physical punishment with short- or long-term effects.
Physical neglect	Willful or negligent acts or omissions by a caretaker that deprive the elder of minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain life or health; failure to provide for a care need despite having the resources or being aware of available resources that could fulfill the need.
Sexual abuse	Any form of involuntary sexual contact including incest, rape, molestation, prostitution, or participation in sexual acts; acts typically perpetrated through threats of force, coercion, or misrepresentation.
Psychological abuse	Verbal assault by a caretaker that dehumanizes and causes mental anguish to the elder, including name calling, ridiculing, humiliating, threatening, or inducing fear of isolation or removal.
Psychological neglect	Failure of the caretaker to satisfy the emotional or psychological needs of an elder, including isolating the elder or not providing social or cognitive stimulation.
Financial/material exploitation	The act or process of using or taking the material goods of an elder for personal or pecuniary gain without consent or authority or through the use of undue influence; including theft, mismanagement, or the blocking of access to their property and contracts.
Violation of personal rights	Taking unlawful advantage of the legally guaranteed rights of the elder, including denied contracting, thus preventing the elder from marriage, divorce, preparing a will, buying, selling, leasing or lending; involuntary servitude, thus preventing the elder from leaving their residence, deciding where to live, or participating in activities such as voting or religious worship; unnecessary guardianship; misuse of professional authority.
Self-neglect	Inability due to physical and/or mental impairments or diminished capacity to perform self-care tasks, maintain physical health and general safety, and/or manage financial affairs.

senting repeat visits and 60.3 percent having previously presented within 30 days (20).

Physical neglect is defined as the refusal or failure to provide for the basic necessities of life, including food, water, shelter, clothing, personal hygiene, medicine, comfort, and personal safety; however, this category is laden with definitional issues related to the multiple underlying etiologies. Some researchers advocate the further subdividing of physical neglect into the categories of active neglect (purposeful withholding of necessities) and passive neglect (legitimate inability of the care provider to perform caregiving duties) based on the intent and capacities of the caregiver (21). Societal ambiguity underlies questions related to the nature and extent of family caretaker duties owed to the elderly, as the term neglect implies a failure to fulfill an obligation (1,22). Conceptual and practical problems of this type have led some researchers to abandon traditional definitions and to conceptualize the problem as inadequate care of the elderly (23) or to propose that a caregiving paradigm be used to formulate intervention strategies (1). However, these models may place the elderly at risk by employing interventions that focus on counseling and education when legal interventions are more appropriate (1).

Sexual abuse is any form of nonconsensual sexual contact or sexual contact with an elder incapable of giving consent and includes rape, sodomy, coerced nudity, molestation, prostitution, and sexually explicit photography. Psychological or emotional abuse is defined as the infliction of mental anguish through verbal acts including name calling, ridicule, humiliation, intimidation, threats, or harassment. Psychological neglect is the nonverbal infliction of mental anguish through use of the "silent treatment" or social isolation. Financial or material exploitation is the illegal or improper use of an elder's funds, property, or assets without permission or through deception. Violation of personal rights is the unlawful obstruction of an elder's legal rights and includes such actions as impeding their right to engage in marriage, divorce, preparation of a will, buy or sell their assets, decide where to live, or the unnecessary establishment of guardianship or misuse of professional authority.

Prevalence

Detection of elder mistreatment parallels the problems of other forms of family violence in that the victims often do not complain because of their perceived dependency on the perpetrator or their fears of reprisal or embarrassment. Additional barriers to detection include cognitive impairments affecting the elder's memory or ability to communicate and the confounding of age-related vulnerabilities with symptoms of mistreatment in situations involving falls, dehydration, malnutrition, and drug toxicity (6). The annual incidence of elder mistreatment has been estimated to range from 4 percent (2) to 10 percent (24,25) in the US aged population, affecting between 700,000 and 2.5 million elders each year (20, 26). The discrepancy in incidence rates has been attributed to methodologic limitations, extrapola-

tion of small samples to the total elderly population of the United States (27), and lack of specificity in elder mistreatment definitions.

In the first large-scale study of mistreatment in community-dwelling elderly, a prevalence of 32 per 1,000 was reported for all types of abuse. Physical violence was the most widespread type, with a prevalence of 20 per 1,000 (28). However, in a study of hospital-based elders, the referrals for neglect occurred at approximately five times the rate as those for physical abuse (29). Although the spouse abuse aspect of elder abuse has not received much attention, several studies suggest that it is a major underlying factor (28,30). In a national family violence study, researchers found husband-to-wife physical violence among 3.3 percent and wife-to-husband violence among 4.2 percent of the married elder respondents (31).

An Illinois statewide review of elder mistreatment reports found that financial exploitation was the most frequently reported abuse (49%), followed by emotional abuse (36%) and neglect (33%) (32). These findings were consistent with others who have noted that financial exploitation is a common type of elder mistreatment (33), particularly among those with dementia (34). Nationwide, there has been a steady increase in the reporting of elder mistreatment. The 293,000 reports filed in 1996 represent a 150 percent increase from 1986 (35). Of the nonself-mistreatment reports that were substantiated in 1996, 55 percent involved neglect, 14.6 percent involved physical abuse, 12.3 percent involved financial/material exploitation, 7.7 percent involved emotional abuse, 0.3 percent involved sexual abuse, 6.1 percent involved other kinds of abuse, and 4 percent were unknown. The victims' median age was 77.9 years, 66.4 percent were white, 18.7 percent were black, 10 percent were Hispanic, and fewer than 1 percent were Native American or Asian Americans/Pacific Islanders (35). The majority of victims (67.3%) were female (36).

Conceptual Framework

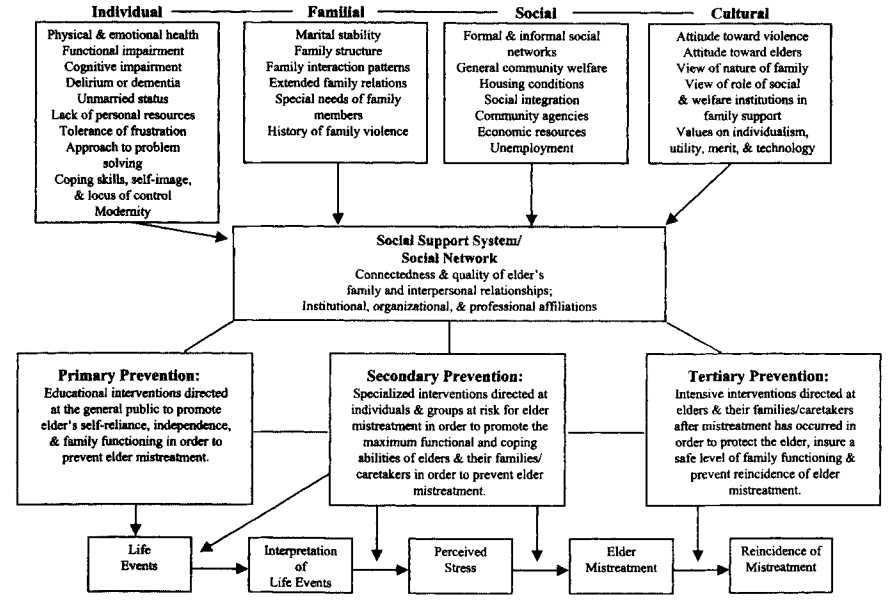
As with other forms of family violence, theoretical perspectives on the causes and correlates of elder mistreatment are many and varied. The inability of the single dimensional models to adequately address the known characteristics of elder mistreatment has resulted in the proposal of several multidimensional models (1,27,37-39). These often address specific types of elder mistreatment such as neglect or spouse abuse. Additionally, the caregiver stress model emphasizes the combination of resentment (generated by the elder's increased financial, physical, and/or emotional dependency) and ineffective caregiver coping (related to the caregivers' increased responsibilities and lack of resources) (40).

An ecological approach has been determined to be the most effective in addressing the problem of family violence, both by experts and by federal funding agencies. The ecological model presented in this article is based on Garbarino's ecological model of child maltreatment (41), which in turn is derived from Brofenbrenner's ecological model of human development (42). Because an ecological model of elder mistreatment was not available, the current model was developed using elder constructs within the context of Howze and Kotch's form. That model offers a framework for considering predisposing variables, available supports, and resources in relation to a topology of four levels: social, cultural, familial, and individual (43). The elder mistreatment model was adapted to address the many overlapping etiologies and to serve as a guide for diagnoses, interventions, and outcomes directed at the primary, secondary, and tertiary levels of elder mistreatment prevention (Figure 1). Dental intervention in elder mistreatment stems from dentist-elder interaction within the context of the social support system-social network. The model is a paradigm for examining the complex interactions among elder victims' and caregivers' characteristics, intra- and extrafamilial stressors, and the social and cultural systems that affect families.

Predisposing Variables

The importance of early identification and intervention lies in its potential for reducing or preventing the occurrence of elder mistreatment. Although the elder mistreatment literature has expanded significantly, there remains a dearth of scientific studies. Most existing knowledge is based on small studies, nonrepresentative samples, clinical reports, and informal surveys (44). Variables that have been associated with elder mistreatment can be classified into four separate domains: social, cultural, familial, and individual. The individual domain has been further delineated to identify characteristics of both the caretaker and the elder victim.

FIGURE 1
Ecological Model of Elder Mistreatment: Implications for Prevention
[Adapted from Ref. 43]



Sociocultural Factors. Although elder mistreatment in the Western world tends to be regarded as a relatively recent phenomenon, research has demonstrated that the view of yesterday's family as a harmonious multigenerational unit that relied on mutual goodwill is largely a myth. In colonial America, the elderly were forbidden entry into towns because it was feared they would increase the almshouses' population, and poor widows were "warned-out" and forced to wander from town to town (45). A 1772 New Jersey law required justices of the peace to search arriving ships for old persons and other undesirables, and to send them away to prevent the growth of pauperism (46). Recent research has indicated that although cultural variations exist that modify the nature of elder mistreatment, it remains a current threat for older adults in many progressively graying societies (47). Ageism, sexism, poverty, unemployment, and disability have long been risk factors for elder mistreatment (16,48).

Modern medical technology has dramatically increased life expectancy resulting in protracted periods of time during which the elderly are susceptible to physical and emotional disabilities and subsequently have greater dependency needs (49). In 1998, there were 34.4 million Americans aged 65 years and older, comprising one-eighth of the country's population (50). Among this group, 18.4 million were aged 65 to 74 years, 12 million were aged 75 to 84 years, and 4 million were aged 85 years and older. According to the US Census Bureau, the "oldest old" (persons aged 85 years and older) are the most rapidly growing segment, with a 274 percent increase since 1960, while the population of those aged 65 years and older has doubled. The "oldest old" population is expected to double in size by 2020, reaching a total of 7 million persons (51).

Although medical technology has produced mechanisms for extending life expectancy, the frail elderly may not be experiencing the same general physical health that might have been experienced by the previous old age survivors (45). Among elderly mistreatment victims referred to social service agencies, the majority are dependent and frail with multiple impairments and it has been proposed that dependency is a major factor in their mistreatment (52). Health professionals have reported that recent cost-containment measures, implemented by hospitals in response to Medicare payment based on diagnostic-related groupings, have resulted in the vulnerable elder being discharged "quicker and sicker" and that such practices represent a form of institutional abuse (53).

The current trends toward smaller family size and more blended families have resulted in fewer offspring who can share responsibility for their own elderly parents and other relatives from current and previous marriages (45). Home visitation services and independent elderly housing can extend the ability of the frail elderly to remain self-sufficient. However, those services are often unavailable in rural or isolated areas. The alternative of relocating to a long-term care facility in an adjacent community may be rejected by frail elderly and their family based on both an underestimation of the elder's care needs and fear of mistreatment within "nursing homes."

Familial Factors. It is estimated that 80 percent of health care for the elderly is being provided by family members (54), and it has been consistently reported that family caregivers are the primary perpetrators of elder mistreatment (3,5,28,48,49,54-59). Researchers have reported that in 86 percent of mistreatment cases the abuser is a relative who lives with the elder approximately 75 percent of the time and has cared for the elder an average of 9.5 years (60). Findings vary as to the nature of the perpetrator's relationship to the victim. Some studies have reported the abuser is most likely the elder's adult child (15,61). However, others found that the perpetrator of mistreatment in 58 percent of the cases was a spouse compared to 24 percent who were adult children (28). Based on a report from the National Center on Elder Abuse, 60.1 percent of the perpetrators of elder mistreatment in 1996 were family members; of all reports, 36.7 percent of the perpetrators were adult children, 10.8 percent were other family members, and 12.6 percent were spouses (36).

Families without a network of relatives to assist with caregiving or who are unaware or unwilling to access community resources place themselves in a precarious and isolated position. It has been reported that community resources are generally less available to the elderly who are cared for by their family than to the isolated individual in the community (49). Trends toward shorter hospital stays and early discharge of elderly patients often result in rushed, unplanned, and unrealistic placement decisions that fail to consider the elder's need for complex physical care, the family's lack of experience in providing such care, and the family's lack of preparedness for the long-term consequences of caring for a family member (62,63).

Individual Caretaker Factors. The unrelenting and constant demands of providing care may lead to caregiver stress and frustration, especially when the elder is mentally or physically impaired, when the caregiver is ill prepared for the task, or when needed resources are lacking (12). Caregiver stress may or may not lead to mistreatment. The likelihood is increased when the caregiver has personal impairments or when professional assistance is unavailable. Studies have indicated that elder-caregiver dependency is a bidirectional risk factor and that the continued dependency of the family caregiver on the elder for financial assistance, housing, or other necessities represents a major risk factor (22,30,64,65). Other identified caregiver risks include a history of emotional illness and/or substance abuse (57,59); psychological impairment including senile dementia or confusion (66); history of being mistreated as a child (5,17); history of violent or antisocial behavior (59); poor health or physical frailty (22); unrealistic expectations and lack of understanding of elder's needs (16); blaming, unsympathetic, hypercritical personality with a lack of empathy or concern for the elder (17); excessive stress, external pressures, and role conflict (60,67); and being overwhelmed and stressed in the caregiver role (22).

Violent behavior has also been associated with the following underlying health conditions: (1) illnesses including hypoglycemia, seizure disorders, central nervous system vasculitis, hyperthyroidism, infections, cardiopulmonary insufficiency, dehydration with resulting electrolyte imbalances, and severe pain; (2) exposure to toxins including carbon monoxide, hydro-

carbons, and inorganic mercury; (3) ingestion, overdose, or withdrawal from psychoactive drugs including alcohol, benzodiazapines, amphetamines, phencyclidine (PCP), corticosteroids, digitalis, lidocaine, pentazocaine, narcotic analgesics, and those with anticholinergic effects that can produce atropinism (atropine, scopolamine, anti-Parkinson, neuroleptics, and tricyclic antidepressants); and (4) major mental disorders including schizophrenia and bipolar affective disorders (68).

Individual Elder Victim Factors. Characteristics that have been reported to place an elder at risk include age >75 years (60), multiple health problems that decrease the elder's ability to function without assistance (69), functional dependence (49), incontinence (22), cognitive loss or dementia (70,71), substance abuse (16), stoicism or failure to blame the caregiver (16,17), financial dependency (49), unnecessarily relinquishing financial management (72,73), and overly demanding behavior (66). Additionally, an elder's violent behavior toward their caregiver, due to the underlying health conditions noted above, may result in defensive or retaliatory violent behavior on the part of the caregiver.

Although some studies have reported that mistreatment is associated with elder frailty or functional impairment, which presumably increases the caregiver's burden (48,74), other studies have generally failed to find a direct relationship (57,75). However, researchers have noted that at minimum, greater impairment probably diminishes elders' ability to defend themselves or escape a mistreatment situation (73).

Stress arising from any of the above domains may be situational, acute, or chronic in nature. However, it should be noted that, to date, research has not indicated any variables present in all mistreating circumstances that are absent in all nonmistreating circumstances. Thus, there is no litmus test for elder mistreatment, only related predisposing variables whose identification provides the opportunity for preventive measures to be directed at stressful environments or interpersonal relationships.

Prevention

Primary preventive interventions are directed at the general population to prevent or reduce the occurrence of elder mistreatment, while secondary preventive interventions are targeted at high-risk groups. Tertiary interventions are focused on preventing further harm to elders who have been mistreated.

Primary prevention of elder mistreatment can be facilitated through professional policy statements, as well as the establishment and distribution of guidelines to help practitioners recognize and report suspected cases. Public health dentistry, along with other public health professions, could coordinate the distribution of public service announcements through the media to educate the general public about the problem, much as has been done with child maltreatment. Posters, magazine advertisements, and radio and television spots can help raise awareness. They could develop and provide practicing dentists with informational brochures pertaining to elder mistreatment for use in waiting rooms.

Educating health professionals about elder mistreatment has been found to be effective in raising awareness and promoting active intervention (10,76). Although greater than 90 percent of a national sample of dentists were aware of elder abuse and neglect as a problem (77), one state sample found only 11 percent of dentists recalled any educational content on elder mistreatment in their professional training programs (10). Another state study found that 82 percent of dental practitioners did not know the mechanism for reporting elder mistreatment, with 78 percent indicating a need to know more about the phenomenon (78). Educational content on domestic violence in professional training programs has been shown to have a positive effect on the rate at which clinicians both suspect and report elder mistreatment (10). Assessment, intervention, and prevention could be further improved with formal educational content in predoctoral training and continuing education on the pathophysiological changes of aging, characteristics of elder mistreatment, advanced gerontological physical assessment, and advanced therapeutic interview techniques. Public health dentistry, by collaborating with organizations such as the American Dental Association and the American Dental Education Association in the writing of policy statements on elder mistreatment, has an opportunity to bring about curricular changes in the nation's dental schools that can be instrumental in the primary prevention of elder mistreatment. At a more grassroots level, public health dentists could deliver presentations on elder mistreatment to local, county, and state dental associations.

Secondary prevention focuses on the at-risk elder who is being treated in the dental office. Dental practitioners need to be better networked with their local Department of Human Services and Department of Public Health, and need to collaborate with their patients' other primary health care providers, including physicians and nurses. At the local level, public health dentists could undertake efforts to ensure that all dental professionals in their community are knowledgeable about the social support resources available, and are able and willing to make appropriate referrals.

Tertiary prevention is aimed at protecting mistreated elders from further mistreatment. When dentists detect maltreatment, they need to be aware that it may not be a first incident. As previously noted, some 80 percent of cases involving physical abuse and neglect are reoccurrences (19). Public health dentistry can help dentists become aware of pertinent statistics and prevalence rates by distributing information to practitioners that will underscore the importance of assessment and intervention in prevention of repeated mistreatment. Dental journals that are widely read by private practitioners are logical places for public health informational editorials and continuing education offerings that focus on elder mistreatment.

Conclusions and Recommendations

During the last 20 years, elder mistreatment increasingly has been recognized as a serious and complex problem with multiple etiologies and manifestations. Although many professional organizations have issued policy statements, identification guidelines, or required affiliates to have policies and procedures for treatment and reporting of mistreated elders (e.g., American Medical Association, American Nurses Association, American Bar Association, and Joint

Commission for Accreditation of Hospitals and Health Care Organizations), organized dentistry has not demonstrated similar efforts (11). A state study found that 82 percent of dental practitioners did not know the mechanism for reporting elder mistreatment, with 78 percent indicating a need to know more about the phenomenon (78). Educational content on domestic violence in professional training programs has been shown to have a positive effect on the rate at which clinicians both suspect and report elder mistreatment (10).

Dentistry has a fundamental responsibility to help remedy the problem of elder mistreatment through professional policy statements and guidelines, and the use of adequate practice-based procedures for treatment and reporting of elder mistreatment. It is vital that dentistry generate research and publications that address the issues of geriatric dental assessment and patient advocacy, thereby providing leadership to primary, secondary, and tertiary elder mistreatment prevention efforts. Public health dentistry, with its focus on education and community awareness, can lend guidance and leadership to all levels of preventive intervention.

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