Chapter 58. Interpersonal Violence

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General Considerations

Interpersonal violence is endemic in the United States. There has been growing public awareness through the media, community advocacy groups, and education in the schools to address this family-based problem. Inextricably tied to social, economic, cultural, and behavioral factors, interpersonal violence requires a multidisciplinary approach by the physician that addresses prevention, detection, intervention, and resolution.

Family physicians must maintain a high index of suspicion for interpersonal violence in their patient populations. Subtle presentations in patient behavior are often difficult to detect, and cultural and social factors may limit the manner and nature of presentation to the physician. Although challenges and opportunities for prevention and intervention are available on a societal level, the family physician is in a unique position to make a meaningful impact before violence escalates.

Interpersonal violence encompasses a wide variety of circumstances. These include:

- Emotional/psychological abuse.
- Financial abuse.
- Neglect (of dependent person).
- Physical violence.
- Sexual violence.
- Stalking, bullying, or internet aggression.
- Homicide.

These manifestations can be further characterized by the status of the individual vulnerable to such acts. Those at greatest risk include children, the elderly, pregnant women, persons who are physically or mentally challenged, immigrants, and members of racial or cultural minorities.

Definitions

Emotional/psychological abuse includes humiliation, controlling behavior, repeated verbal assaults (name-calling), isolation (rejection, withholding attention and affection), threats, and public harassment, all of which can produce psychological trauma that reduces a person's self-worth, value, and sense of efficacy. Emotional/psychological violence often coexists with chronic physical or sexual violence, but can also stand alone.

Financial abuse is when a person withholds resources such as money or transportation, or limits freedom of movement or association (eg, domination, isolation) of another person—a tactic often found in abusive relationships. Financial abuse most often involves the inappropriate transfer or use of an elder's funds for the caregiver's purposes.

Neglect is the chronic failure of a person who is responsible for the physical and emotional needs of another person to provide for those needs. This form of abuse most often occurs in family relationships and is directed at children, elders, or disabled family members. However, caregivers in other social/community settings, including child and adult day care, schools, group homes, nursing facilities, and hospitals, may be involved in neglect of a dependent person.

Physical violence, as defined by the Centers for Disease Control and Prevention (CDC), is the "intentional use of physical force with the potential for causing death, disability, injury, or harm." This includes, but is not limited to, the following acts: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and use of restraints or one's body, size, or strength against another person. In the most extreme cases, physical violence may involve **homicide**.

Sexual violence, according to the CDC, is defined as "any sexual act that is perpetrated against someone's will. Sexual violence may include a completed nonconsensual sex act (ie, rape), an attempted nonconsensual

sex act, abusive sexual contact (ie, unwanted touching), and noncontact sexual abuse (eg, threatened sexual violence, exhibitionism, verbal sexual harassment). It includes the following four types:

- **"A completed sex act** is defined as contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object."
- **"An attempted (but not completed) sex act."**
- **"Abusive sexual contact** is defined as intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse."
- **"Noncontact sexual abuse** does not include physical contact of a sexual nature between the perpetrator and the victim. It includes acts such as voyeurism; intentional exposure of an individual to exhibitionism; unwanted exposure to pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse."

Stalking, bullying, or internet aggression may take the form of harassment, threats, or physical violence that can lead to emotional or physical injury, and in some cases death. In its definition for stalking, CDC includes acts such as repeatedly following a person, appearing at a person's home or place of business, making harassing phone calls or leaving objects or written, text, or internet messages, or vandalizing a person's property. In addition to these acts, bullying can include spreading rumors, teasing, social isolation, and influencing others to "gang up" on someone in person or through aggression on the internet.

Web Site

Centers for Disease Control and Prevention fact sheet on interpersonal violence:
http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html

Epidemiology

Numerous studies have revealed disturbing evidence about the magnitude of interpersonal violence in the US society as well as opportunities for intervention. An estimated 25% of women and 7.9% of men are victimized at some point in their lives by a former spouse, cohabiting partner, or date. In one survey, 7.7% of women and 0.3% of men reported having been raped, and 22.1% of women and 7.4% of men had been physically assaulted. A typical respondent male victim averaged 4.4 physical assaults while women averaged 6.9 physical assaults. Thus, repeat victimization offers an opportunity for physicians to identify and intervene with persons at risk.

The annual incidence of all interpersonal violence has been estimated at 47 assaults per 1000 women and 32 assaults per 1000 men. Other estimates suggest that as a result of the 1.3 million women and 800,000 men who are physically abused in the United States each year, there are over 2 million injuries and 1300 deaths. Of particular concern is the finding that persons living in homes in which violent acts occur are more than four times as likely to be involved in additional violent acts than are those living in homes that are violence free.

Children, pregnant women, and the elderly are particularly vulnerable groups. Each year approximately 800,000 children in the United States are identified as victims of family violence or neglect. Half of homeless women and children report fleeing domestic violence. Pregnant women are at a greater risk of suffering physical abuse. It is a sobering fact that homicide is the leading cause of maternal death in the United States, and each year between 1,500 and 1,800 children die from abuse or neglect. Additionally, more than 500,000 elders are abused or neglected in domestic settings each year.

In mixed-sex domestic violence, the female partner is 30% more likely to be killed than the male partner, and most of these murders are committed with firearms. Although 28% of female homicide victims were killed by their current or former male partners, only 3% of men were murdered by current or former female partners.

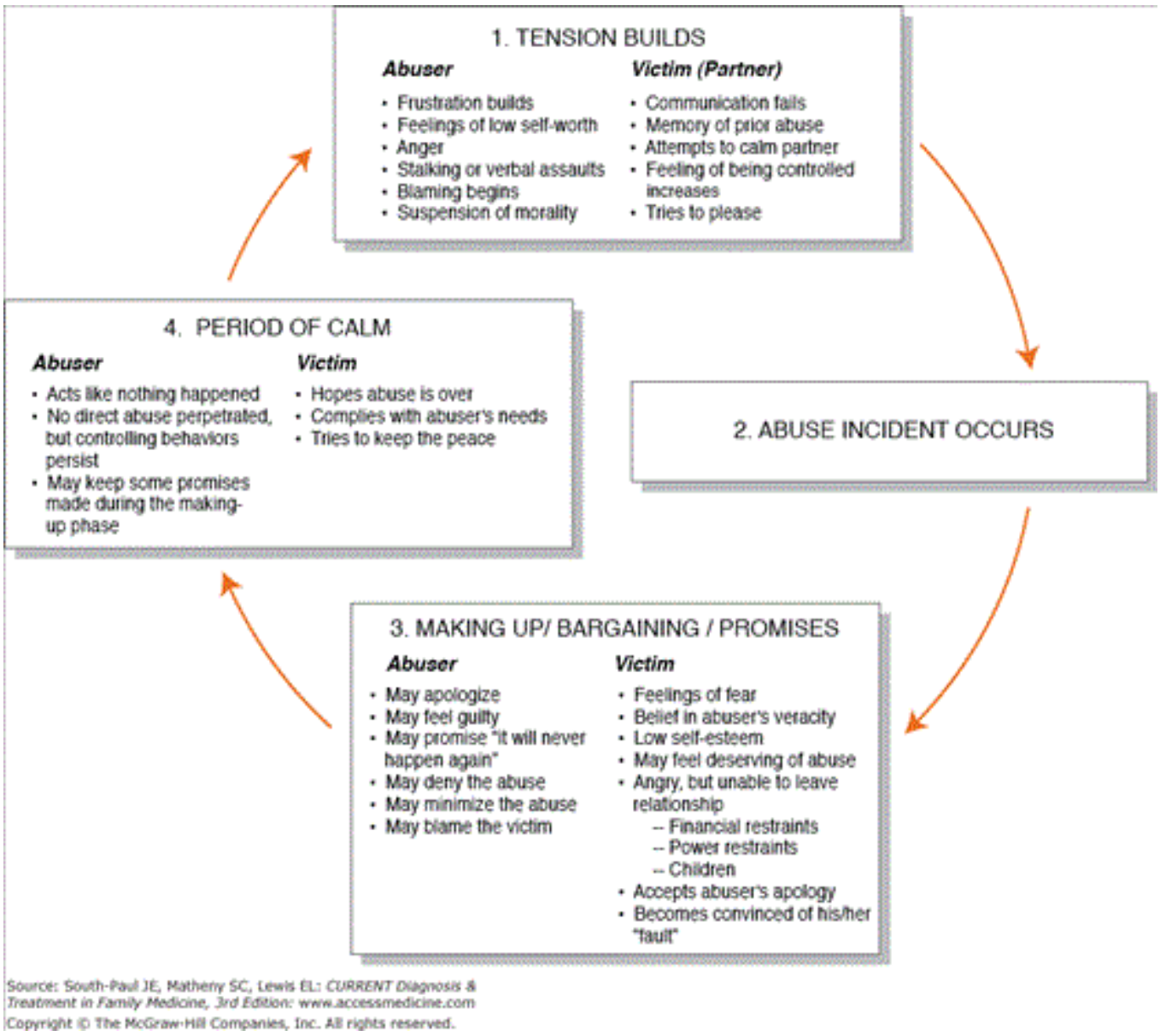
African American, American Indian, and Alaska Native women and men report higher rates of domestic violence than the population as a whole, but socioeconomic factors confound the interpretation of such data. African Americans have a spousal homicide rate 8.4 times that of whites, whereas partners in interracial marriages have similar rates.

Other studies indicate a higher number of unreported incidents of physical and sexual abuse. More difficult to measure is emotional/psychological abuse or neglect, which is often insidious and difficult to detect.

Natural History of Interpersonal Violence in Adults

Interpersonal violence among known partners occurs in cycles. Although there are clear steps to the cycle of violence, this should not imply that there is no escalation. In fact, with each cycle the victim is exposed to additional risk. Similar cycles have been found with elder abuse, child abuse, and sexual predatory behavior. The steps in known partner abuse are outlined in Figure 58-1.

FIGURE 58-1.



Steps in the cycle of interpersonal violence. With each new cycle the level of violence usually escalates.

Detection & Intervention

Refer to Chapter 42 for more detailed information about abuse in the elderly.

Adults

Identification and Screening

To identify cases of interpersonal violence, it is essential that family physicians maintain a high index of suspicion at all times. Victims of abuse often feel ashamed, have low self-esteem, or are unable to share their circumstances readily. Creating an atmosphere that promotes a welcoming, frank, and professional discussion will allow patients the opportunity to bring their concerns forward to the physician.

Screening tools have been advocated; however, the value of these tools for domestic violence has not been clearly demonstrated. Because of a lack of specific studies, the US Preventive Services Task Force has issued an "I" recommendation on methodologies of screening for family and intimate partner violence, indicating that there is insufficient evidence for or against the use of such tools.

http://www.cdc.gov/violenceprevention/pub/IPV_cost.html

The American Medical Association and American College of Obstetricians and Gynecologists recommend specific direct questioning of patients, when appropriate, in a nonthreatening manner. The policy of the American Academy of Family Physicians regarding family violence can be found at the association's web site (*http://www.aafp.org/x16506.xml*).

Several simple screening questions may be of value in the patient interview and should be incorporated by the physician when taking a relevant history, at the time of the well visit, or when screening for other diseases. Much like screening for alcohol abuse or depression, low-threat questions can be incorporated to ascertain the possibility of abuse in the home situation (Table 58-1). Often, these questions can be incorporated into a history or review of symptoms questionnaire with little difficulty. Periodic rescreening of patients is advised.

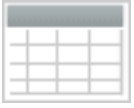


Table 58-1. Screening Questions for Interpersonal Violence in Adults.

The use of prompts in electronic medical records is an interesting area of development. Certain complexes, complaints, and findings could trigger a reminder for the physician to ask a question about violence in the home or workplace. Much research remains to be done to ascertain the value of such prompting.
Additional questions have been proposed by various advocacy groups. Screening questions suggested for attorneys can be adapted by the family physician and obtained from the American Bar Association web site at *http://www.abanet.org/domviol/screeningtoolcdv.pdf*. Valuable tools for identifying violence exposure and related symptoms can also be found on the Veterans Administration web site at *http://www.ptsd.va.gov/public/index.asp*. Family physicians should endeavor to become familiar with a wide range of potential questions in order to utilize an appropriate approach from a wide repertoire.
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Interventions
The abusive spouse/partner or family member often accompanies the patient to the office visit to monitor the information being delivered and the manner in which it is portrayed by the victim. Although it is not abnormal for a spouse or significant other to attend a physician visit, the physician should be alert to cues, including nonverbal behaviors that might signal an abusive situation. In particular, physicians should carefully evaluate situations in which someone else does all the talking for a competent and able patient.
Perpetrators of abuse often have a history of interpersonal violence in their family of origin or were victims of nonfamily interpersonal violence at some point in their lives. It is often difficult to identify the inciting event, because frank communication with those who perpetrate violence is usually difficult. Insecurity, anger, a need to control, and moral issues are often complicated by defensiveness, shame, embarrassment, low self-esteem, and fear on the part of the abuser. Often, abusive individuals have no viable model of behavior in which to contextualize the intervention of a physician; to avoid being the victims of a confrontation, they may revert to controlling behavior in the office or become

aggressive. Physicians must consider the safety of their staff when confronting such individuals.

Intensive therapy is often required for both the abuser and the victim and resources should be readily available in health practices. A period of physical separation is often required initially for the safety of the victim. Referral to an appropriate safe house in the community and obtaining a personal protective order from a judge are important first steps, and the patient should be encouraged to take these steps, if appropriate. The use of an advocate, volunteer or paid, is of great value in assisting the victim to follow through with these initial steps. Legal advice is often necessary, and family physicians should have a list of resources available for patients to seek legal advice early in the process.

During this period, therapy for the victim is aimed at improving objective decision making, reestablishing self-esteem, reversing the cycle of self-blaming, and addressing the reality of the situation. Reality-oriented interventions complement insight-based approaches. Objective testing of victim hypotheses of what happened often results in greater fear, so a supportive, encouraging therapist and environment are required. Eventually, group therapy can be utilized when the victim has reorganized his or her thoughts and is able to share experiences in a productive way with others.

The abuser also requires therapy. Depending on the circumstance, this may occur in the penal system or be mandated by the courts to take place in a child welfare agency. Therapy is aimed at reordering the emotional responses of the abuser and improving self-esteem. Developing a new worldview and set of behaviors is very difficult and takes a great deal of effort on the part of the therapist and the abuser. Family therapy may have a place in the early stages of the cycle of violence. If both the abuser and the victim recognize the maladaptive pattern of behavior in their arguments prior to the onset of physical or severe emotional abuse, couple's counseling may be successful in ending the cycle of violence. However, communications skills training alone may not be enough to create a change in behaviors. A few evidence-based treatments for children and offending and/or non-offending caregivers also exist and are well supported by research (see Chadwick Center: *http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf*).

Consideration needs to be given to the patient's spiritual, ethnic, and cultural background in order to place any intervention into a context that will maximize its success. "One size fits all" therapies may not have lasting benefit. It is critical that the family physician be supportive of the therapist and encourage the victim to continue in therapy. "Relapse" rates (ie, returning to the abusive relationship) are high; physicians should not become judgmental about such reconciliations but rather should remain supportive of victims.

Children

Specific and direct questioning about childhood injuries is advocated by emergency physicians and pediatricians. Direct questioning of parents/caregivers should be done in private to maximize value, maintain confidence, and reassure family members of the physician's intent to help, not hurt, the child or the family. This may require or be best facilitated by a multidisciplinary team trained to assess and report child abuse, neglect, or other forms of child victimization.

There are specific cues that should heighten the physician's index of suspicion regarding domestic violence and child abuse. "Red flags" should be raised when

- One partner insists on accompanying the other parent and child, and speaks for them.
- A parent is reluctant to talk with the other partner present.
- The child's history does not fit the injury or illness.
- A parent makes frequent appointments for vague, poorly defined complaints.
- A child has recurrent, medically unexplainable somatic problems (eg, failure to thrive, abdominal or genital pain or injuries, headaches, enuresis (wetting), encopresis (fecal soiling), problems eating or sleeping).
- Medical attention for injuries is sought later than would be expected.
- The family uses emergency department services more often than is usual.
- A parent attempts to hide the child's injuries with clothing.
- A parent or child has several injuries, at various stages of healing.

Additional red flags are outlined at *http://childabuse.stanford.edu/screening/signs.html*. Accessed August 19,

2010.
http://www.iowaepsdt.org/EPSDTNews/2000/sum00/guide.htm.
Accessed on October 5, 2010.
Family physicians should be alert to the symptoms and signs of potential child abuse or neglect listed in Table 58-2.
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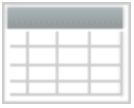

Table 58-2. Symptoms and Signs of Potential Abuse and Neglect in Children.

It is also important to recognize that children may have interpersonal violence experiences other than child abuse or neglect by family members that can manifest in similar ways in terms of health, mental health, and functional impairments. These include sexual exploitation; witnessing violence in their communities (eg, shootings, stabbings); bullying at or after school by peers, older children, or adults; and electronic aggression (eg, harassment or bullying that occurs through e-mail, chat rooms, instant messaging, web sites [including blogs], or text messaging).

Special Populations
Several groups within the US population are especially vulnerable to interpersonal violence. These groups include recent immigrants, ethnic and racial minorities, the homeless, people with disabilities, and gays and lesbians. (For additional discussion on gays and lesbians, see Chapter 62.)
Vulnerable populations, including those with physical or mental challenges, may find it difficult to contextualize their experience or communicate it in a manner the physician can understand. Patience and time are warranted. Followers of some religious and cultural traditions may tolerate levels of behavior that are not accepted by the mainstream culture in the United States. This is not to say that some cultural paradigms are inherently more violent than others; rather, the norms of acceptable or expected behaviors, including the sharing of intimate family details, create additional challenges to discovery of aberrant and abusive relationships for the physician. These challenges may apply to a wide variety of behaviors, including child-rearing, depression and other mental

health problems, and sexuality concerns.

The key to identification of abuse in these situations is an understanding of cultural influences. To this end, enlisting the collaboration of an advocate who has proper training and connection with the culture is essential. This person may also play an important role in supporting the patient's decision making when seeking appropriate interventions. Open-ended questions about a patient's cultural norms may provide an appropriate avenue and manner for inquiry into the presence or absence of interpersonal violence in the patient's life. An inherent lack of trust in law enforcement may be a specific challenge in poor minority communities and among the homeless. Misunderstanding of interpersonal violence and the stigma associated with it may inhibit reporting or seeking of assistance. Additional information can be obtained from specific resources such as the University of Michigan Program for Multicultural Health, available at *http://www.med.umich.edu/multicultural/ccp/cdv.htm*. A resource for the African American community is available at *http://www.dvinstitute.org*, and for the American Indian or Alaska Native community is *http://www.tribal-institute.org/lists/domestic.htm*.

The possibility that partners in same-sex relationships may be victims of interpersonal violence is sometimes overlooked. A wide range of social factors may contribute to underreporting of abuse in this population, and frequency of physical and sexual abuse may be higher than most physicians would expect. Gay and lesbian patients should be questioned, as all patients are, in a safe environment and in a nonthreatening manner. In a recent study of a random sample of 284 gay or bisexual men, almost all respondents indicated that they had experienced psychological abuse, more than one-third reported physical abuse, and 10% reported having engaged in unwanted sexual activity because of partner force or threats of force. More than half of recipients of partner violence reported sustaining injury.

Prevention

Given the pervasiveness of interpersonal violence, and the inherent difficulties of detection and intervention, methods of primary prevention are of critical importance in addressing this problem. The effectiveness of prevention programs remains an ongoing topic of study.

Family physicians should consider a routine discussion of interpersonal violence as part of the normal health maintenance routine. This can be part of the usual discussion of safety issues, including seat belt use, gun safety, and smoke protectors. In a matter-of-fact manner, the physician can introduce the discussion of interpersonal violence in a wide variety of contexts, including well-woman care, well-child visits, routine "physicals," and other health maintenance visits.

A routine discussion of parenting techniques, referral to appropriate parenting classes, and provision of printed information have all been shown to have a positive effect on families at risk for child abuse or neglect. A plan for abuse identification, prevention, and training can be part of the individual education plan and the transition plan for children with developmental and physical disabilities.

Living situations of elderly patients should be well documented and understood, especially if the caregivers are not well known or are not part of the physician's personal practice. Information obtained and communication established during times of calm may be useful later should an incident occur.

Safety Instructions for Patients

The American Bar Association provides a domestic violence safety plan on its web site at *http://www.abanet.org/tips/dvsafety.html*. Adult patients can be referred to this resource for updated recommendations on how to protect themselves in situations in which interpersonal violence is an imminent threat. Family physicians should also be aware of local

resources and update contacts with them annually to ensure a readily available system of referral for safe houses, therapeutic care or social services, and legal intervention. Although these options vary from community to community, local resources can usually provide assistance to physicians when dealing with complicated cases.

Reporting

Healthcare providers should familiarize themselves with the laws of their state regarding the required reporting of violent crimes. In general, acts of violence that involve lethal force or firearms and rape must be reported to the local police agency. Adequate and complete documentation of all encounter details—including quotations, details, and time requirements—is an important medicolegal requirement. Family physicians working in emergency departments should follow the policies and procedures of their institution in the management and reporting of such violent crimes.

The reporting of an individual's confidentially expressed intent to harm another person places the physician in a far more difficult ethical and legal position that may require legal advice. In emergencies, particularly when a patient is believed to be in danger, the patient should be told to call 911.

The reporting of child abuse to Child Protective Services is a requirement in all 50 states. Some states require reporting to the local police agency as well. It is important for physicians to know the laws in their state (see Child Information Gateway: *http://www.childwelfare.gov/systemwide/laws_policies/state/*). Reporting requirements and processes vary and many non-accidental injuries and their consequences are under-addressed in medical settings.

The Child Welfare Information Gateway provides telephone numbers for each state hotline: *http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172*. To aid a physician's understanding and ease any anxiety associated with reporting, physicians should learn the process for reporting in their county or state and what happens after child victimization is reported to Child Protective Services.

Elder abuse is also covered by state laws, and physicians should report in accordance with the local law at the time of the suspected abuse. In general, Adult Protective Services (APS) should be notified of suspected neglect or abuse. Other agencies that may require notification, depending on the state, include the Area Agency on Aging and the County Department of Social Services.

Ahmad M, Lachs MS: Elder abuse and neglect: what physicians can and should do. Cleve Clin J Med 2002;69:801.This node is not processed by any templates: ci-online [PubMed: 12371803]

Web Sites

American Bar Association Commission on Domestic Violence: *http://www.abanet.org/domviol/*

Child Welfare Information Gateway: *http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172http://www.childwelfare.gov/*

Feminist Majority Foundation fact sheet on domestic violence: *http://www.feminist.org/other/dv/dvfact.html*

Table 58-1. Screening Questions for Interpersonal Violence in Adults.
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1. Do you feel safe in your current relationship?
2. Do you perceive any threats to your safety on a regular basis?
3. Have you been hit or hurt by someone in the past?
4. Would you care to share any concerns you might have regarding interpersonal violence in your home or among your friends?
5. Have you ever been or are you currently concerned about harming your partner or someone close to you?
6. Would you like information about interpersonal violence or substance abuse programs in our community?

Physical Abuse	**Neglect**	**Emotional Abuse**	**Sexual Abuse**
Burns	Malnutrition	Self-injury	Self-injury
School problems	Lack of supervision	Anger	Inappropriate sexuality for age/seductiveness
Self-destructive or suicidal behavior	Poor dental hygiene	Depression	Genital swelling, bruises, bleeding, sexually transmitted infections, yeast or urinary tract infections, pregnancy
Unexplained cuts, bruises, or welts	Inappropriate clothing	Apathy	Poor hygiene
Inappropriate fear of adults	Poor hygiene	Eating disorders	Eating disorders
Early-onset depression, alcohol	Extreme	Anxiety	Sleep disorders

or drug use	hunger		
Bruises in the shape of objects		Anger	Excessive aggression
Injuries in uncommon locations			Fear of a particular person
Bite marks			Withdrawal Suicidal behavior

Table 58-2. Symptoms and Signs of Potential Abuse and Neglect in Children.

Chapter 42. Elder Abuse

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General Considerations

As hidden as the other forms of family violence may be, domestic elder abuse is even more concealed within our society. Elder abuse was first described in the literature in 1975, when the first reports of "granny battering" appeared. Vastly underreported, only one in four domestic elder abuse incidents (excluding the incidents of self-neglect) come to the attention of authorities.

The most common reporters of abuse are family members (17%) and social services agency staff (11%). Physicians reported only 1.4% of the cases. Although physicians are mandatory reporters in all states, many physicians feel ill-equipped to address this important social and medical problem. Health care professionals consistently underestimate the prevalence of elder abuse. Concerns for patient safety and retaliation by the caregiver, violation of the physician-patient relationship, patient autonomy, confidentiality, and trust issues are quoted as reasons for low reporting. A recent survey indicates that more than one-third of health care professionals had detected cases of elder abuse in the past year.

Family physicians are particularly well positioned to assist in identifying and managing elder abuse. Family medicine residencies focus on training residents regarding elder abuse more comprehensively than other primary care programs. Except for the primary caregivers, they may be the only ones to see an abused elderly patient. Older victims who suffer from neglect, self-neglect, or physical abuse are likely to seek care from their primary care physician or gain entry into the medical care system through an emergency department.

In the 2000 census, 35 million people in the United States were 65 years of age and older. Adults 85 years and older showed the highest percentage increase of any age group (38%), from 3.1 million to 4.2

million. As the baby boomers age, the number of elders in the United States will continue to increase. The societal cost for the identification and treatment of elder abuse is also projected to rise as the baby boomers enter the elder years.

Definition and Types of Abuse

Elder abuse is an all-inclusive term that describes all types of mistreatment and abusive behaviors toward older adults. The mistreatment can be either acts of commission (abuse) or acts of omission (neglect). Labeling a behavior as abusive, neglectful, or exploitative can depend on the frequency, duration, intensity, severity, consequences, and cultural context. Currently, state laws define elder abuse, and definitions vary considerably from one jurisdiction to another. Research definitions also vary, making it difficult to review comparative data.

There are three basic categories of elder abuse: (1) domestic elder abuse, (2) institutional elder abuse, and (3) self-neglect or self-abuse. The National Center on Elder Abuse (NCEA) describes seven different types of elder abuse: physical abuse, sexual abuse, emotional abuse, financial exploitation, neglect, abandonment, and self-neglect

Prevalence

According to the 2003 National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, it is estimated that approximately one to two million elders were victims of various types of domestic elder abuse, excluding abuse due to self-neglect. More than 2%-10% of the nation's elderly may be victims of moderate to severe abuse, but because of underreporting, poor detection, and differing definitions, the true estimate of elder abuse may be far greater. It is estimated that for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, about five more go unreported. Current estimates put the overall reporting of financial exploitation at only 1 in 25 cases, suggesting that there may be at least five million financial abuse victims each year. In a recent survey of almost 6000, there was a 1-year prevalence of 4.6% of emotional abuse, 1.6% of physical abuse, 0.6% of sexual abuse, 5.1% of potential neglect, and 5.2% of financial abuse by a family member.

In reported cases of domestic elder abuse, 77% of the victims were white and 22% were African American. The proportions of Native Americans and Asian Americans/Pacific Islanders were each less than 1%. Neglect—the failure of a designated caregiver to meet the needs of a dependent elderly person—is the most common form of elder maltreatment in domestic settings. In almost 90% of cases the perpetrator of the abuse is known, and in two-thirds of cases the perpetrators are spouses or adult children.

Risk Factors

Several explanations have been proposed to explain the origins of elder mistreatment. These explanations have focused on overburdened caregivers, dependent elders, mentally disturbed caregivers, a history of childhood abuse and neglect, and the marginalization of elders in society. Care setting also seems to influence risk of elder abuse. Paid home care has a relatively high rate of verbal abuse and assisted living settings have an unexpectedly high rate of neglect. Moving from paid home care to nursing homes has been shown to more than triple the odds of the elder experiencing neglect. Risk factors commonly cited for elder mistreatment are listed in Table 42-2.

From the Indicators of Abuse (IOA) screen, a profile of the abuser has been developed that can identify abuse cases 78%-85% of the time.

A typology of abusers has also been suggested to better delineate who may perpetrate abuse. Five types of offenders have been postulated:

- *Overwhelmed offenders* are well intentioned and enter caregiving expecting to provide adequate care; however, when the amount of care expected exceeds their comfort level, they lash out verbally or physically. The maltreatment is usually episodic rather than chronic. This type of offender is often seen in long-term care settings.
- *Impaired offenders* are well intentioned, but have problems that render them unqualified to provide adequate care. The caregiver may be of advanced age and frail, have physical or mental illness, or have developmental disabilities. This type of maltreatment is usually chronic and the caregiver is unable to recognize the inadequacy of

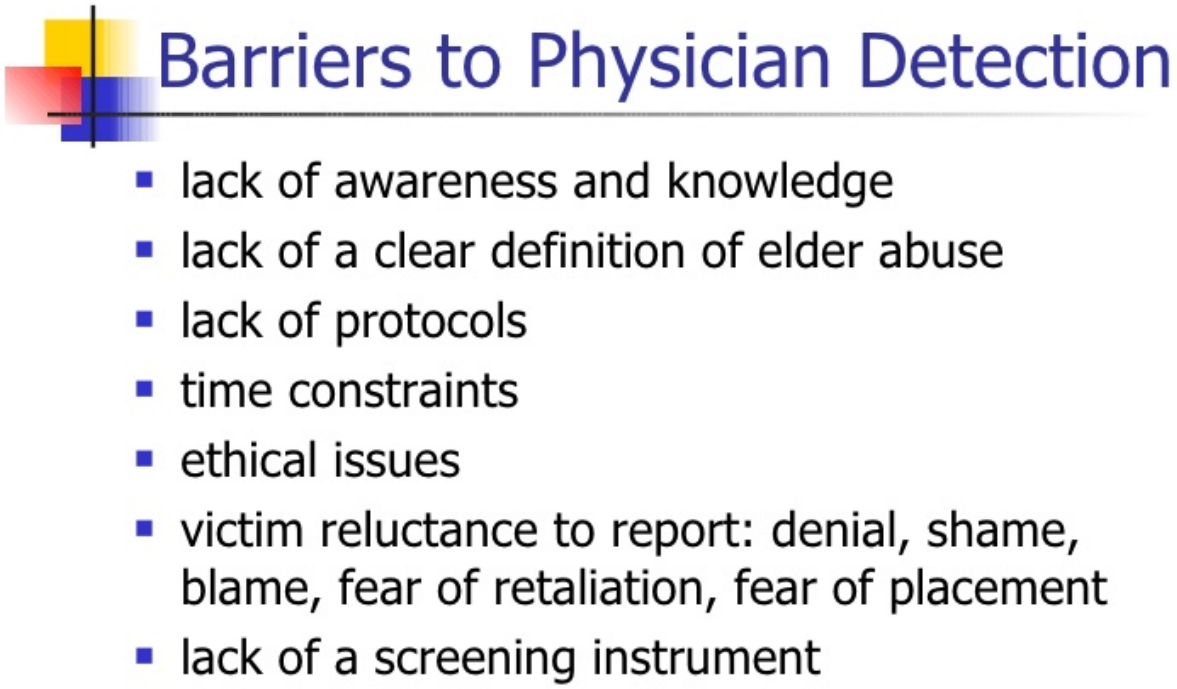
the care. Neglect is frequently observed in these cases.

- *Narcissistic offenders* are motivated by anticipated personal gain and not the desire to help others. These individuals tend to be socially sophisticated and gain a position of trust over the vulnerable elder. Maltreatment is usually in the form of neglect and financial exploitation and is chronic in nature. These offenders will also use psychological abuse and physical maltreatment to obtain their objective. This type of offender may work in a long-term care facility and become involved in stealing from the residents.
- *Domineering or bullying offenders* are motivated by power and control and are prone to outbursts of rage, believing their actions are justified by rationalizing that the victim "deserved it." These offenders know where and when they can get away with abuse. This abuse is chronic, multifaceted, and ongoing with frequent outbursts of temper. Abuse takes the form of physical, psychological, and even forced sexual coercion. The victims are fearful, and the abuser may lash out when confronted or attempt to manipulate those who confront them.
- *Sadistic offenders* derive feelings of power and importance by humiliating, terrifying, and harming others. They have sociopathic personalities and inflict severe, chronic, and multifaceted abuse. Signs of this type of abuse include bite, burn, and restraint marks and other signs of physical and sexual assault. The victims are fearful and experience terror. If confronted, the abuser may attempt to charm and manipulate or intimidate and threaten the accuser in an attempt to control professionals who are trying to stop the abuse.

Clinical Findings

Several medical and social factors make the detection of elder abuse more difficult than other forms of family violence. Given the higher prevalence of chronic diseases in older adults, signs and symptoms of mistreatment may be misattributed to chronic disease, leading to "false negatives," such as fractures that are ascribed to osteoporosis instead of physical assault. Alternatively, sequelae of many chronic diseases may be misattributed to elder mistreatment, creating "false positives," such as weight loss because of cancer erroneously ascribed to intentional

withholding of food. Another significant issue for the physician is denial that the reason for the presentation into the health care system could be attributable to abuse.
Physician barriers to reporting elder abuse are listed.



Screening
The US Preventive Services Task Force (USPSTF) found insufficient evidence to recommend for or against routine screening of older adults or their caregivers for elder abuse. The American Medical Association recommends that all older patients be asked about family violence even when evidence of such abuse does not appear to exist. A careful history is crucial to determining if suspected abuse or neglect exists. The elderly dependent patient may fear retaliation from the abuser and may be reluctant to come forward with information. The physician should interview the patient and caregiver separately and alone, and if the caregiver does not allow this, abuse potential should be considered.

General questions about feeling safe at home and who prepares meals and handles finances can open the door to more specific questions about disagreements with the caregiver and how these disagreements are handled, such as the caregiver yelling, hitting, slapping, kicking, or punching; making the elder wait for meals and medications; or confining the elder to a room. It is also important to inquire about the possibility of sexual abuse (unwanted touching), financial abuse (stolen money, signing legal documents without understanding the consequences), and finally threats of institutionalization.

The caregiver interview should avoid confrontation and blame. The physician needs to appear sympathetic and understanding of the abuser's perceived burden in caregiving. The physician should be alert to a caregiver who has poor knowledge of a patient's medical problems, has excessive concerns about costs, dominates the medical interview, or is verbally aggressive either to the patient or physician during the interview. A caregiver with substance abuse or mental health problems and one who is financially dependent on the elder should also alert the physician to a greater potential for abuse. Identification of abuse is critical to the health of the elder given the fact that data demonstrate that mortality is increased dramatically once abuse is identified.

Physical Examination

A thorough physical examination is the initial invitation to recognizing and documenting elder abuse. Particular attention to the functional and cognitive status of the elder is important to understanding the degree of dependency that the elder may have on the caregiver. The primary care physician may be confronted with subtle forms of ongoing abuse or mistreatment in which neglect and psychological abuse predominate. Behavioral observations of withdrawal, a caregiver who treats the elder like a child, or a caregiver who insists on giving the history should heighten the clinician's suspicions.

Detailed documentation of the physical examination is important as it may be used as evidence in a criminal trial. Documentation must be complete and legible, with accurate descriptions and annotations on sketches or, when possible, with the use of photo documentation.

Intervention & Reporting

Once elder abuse is suspected, all health care providers and administrators are legally obligated to report the abuse to the appropriate authorities. Most states have anonymous reporting and Good Samaritan laws that can offer an alternative to a direct physician report if there are significant concerns for maintaining the physician-patient relationship. As previously noted, laws differ from state to state, and physicians should become familiar with the specific reporting requirements of their state. By emphasizing the diagnosis and treatment of the health consequences of the mistreatment or the abuse, the elderly patient and caregiver may feel less threatened. Reporting should be done in a caring and compassionate manner in order to protect the autonomy and self-worth of the elder while ensuring his or her continued safety.

The victim should be told that a referral will be made to Adult Protective Services (APS). Involving the caregiver in the discussion must be carefully considered with regard to potential retaliation on the victim. The law enforcement implications of APS should be downplayed and the social support and services offered by APS should be offered as part of the medical management of the victim. Victims may deny the possibility of abuse or fail to recognize its threat to their personal safety. In the event of financial abuse the victim or the offender, or both, may not acknowledge the abuse. If the victim refuses the APS referral, the clinician may explain that he or she is bound to adhere to state laws and regulations in making the referral and that the regulations were developed to help older persons who were not receiving the care they needed for whatever reason.

The safety of the patient is the most important consideration in any case of suspected abuse. If the abuse is felt to be escalating, as may occur with physical abuse, law enforcement as well as APS should be contacted. Hospitalization of the elder may be the only temporary solution to removing the victim from the abuser.

If elders are competent and not cognitively impaired, their wishes to either accept interventions for suspected abuse or refuse those interventions must be respected. If an abused elder refuses to leave an abusive environment, the primary care physician can help by providing support

and whatever interventions the older person will accept. Helping the older victim to develop a safety plan, such as when to call 911, or installing a lifeline emergency alert system may be part of the management plan. Close follow-up should be offered.

If older victims no longer retain decision-making capacity, the courts may need to appoint a guardian or conservator to make decisions about living arrangements, finances, and care. This is typically coordinated through APS. The physician's role in these cases is to provide documentation not only of the physical findings of abuse but also of impaired decision-making capacity.

Intervention can be complicated when professionals suspect self-neglect or self-abuse. Many people are capable of understanding and accepting the consequences of their actions, but they make decisions with which their families or professionals disagree. Assessments of cognition and decision-making capacity are critical if we are to execute our mandate to assist and protect without treading upon civil rights. Further complications may ensue when these individuals refuse assessment. The role of family, clergy, and other community organizations can be difficult because of HIPAA and other confidentiality guidelines. Behavioral health professionals, ethics committees, the guardianship process, and court system are invaluable in assisting families and primary care physicians with these very challenging situations.

As the growth of the elderly population in the United States continues, physicians will need to use vigilance to identify and assist patients at risk for elder abuse. Geroff and Olshaker have provided a framework to help the physician with this potentially overwhelming task. The primary care physician's role is to recognize or suspect abuse in its various forms, treat the medical problems associated with the abuse, and provide a safe disposition for the patient. The additional evaluations, assessments, and long-term follow-up may be provided by a team of social workers, APS personnel, attorneys, and other members of the traditional health care team. The initial assessment by the primary care or emergency physician may start these crucial interventions.