ELDER ABUSE
AND NURSING
Carol A. Miller, MSN, RN-BC, has cared for older adults in homes, hospitals, hospice settings, a geropsychiatric program, long-term care facilities, and many community-based programs for more than four decades. Her roles have included nurse practitioner, geriatric care manager, clinical nurse specialist, consultant, administrator, interprofessional team member, and staff nurse. In all these roles and settings, she has provided nursing care for hundreds of older adults who are in abusive or potentially abusive situations. Ms. Miller’s interest in elder abuse began in 1978 when she served on the staff of the U.S. House of Representatives, Select Committee on Aging and was involved with organizing hearings and developing legislation to address elder abuse at the federal level. Since then, in addition to her clinical practice, she has participated in research and presented at numerous local, state, and national conferences on various aspects of elder abuse and gerontological nursing.

Ms. Miller has held various faculty positions at the Frances Payne Bolton School of Nursing at Case Western Reserve University and a host of other nursing programs. She is widely published in nursing journals and is the sole author of several nursing texts, including Fast Facts for Dementia Care (Springer Publishing Company) and Nursing for Wellness in Older Adults, 7th Edition, which won a Book of the Year award from the American Journal of Nursing in 2015.
ELDER ABUSE AND NURSING

What Nurses Need to Know and Can Do About It

Carol A. Miller, MSN, RN-BC
I dedicate this book to the memory of my dear friend and colleague, Betty Lau, whose pioneering work in elder abuse set the wheels in motion for national legislation to address elder abuse. On a clinical level, it was a privilege to work with Betty as one of the many professionals who not only cared about preventing elder abuse, but also took action to address the needs of older adults who were in actual or potential elder abuse situations.

Perhaps most importantly, I dedicate this book to older adults, with the hope that nurses and other professionals will apply the content to prevent elder abuse and address the consequences as we provide care.
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CONTRIBUTORS AND REVIEWERS

CONSULTANT AND REVIEWER FOR THE BOOK
Georgia J. Antezberger, PhD, ACSW

CONTRIBUTORS, CHAPTER 14
BENJAMIN ROSE INSTITUTE ON AGING (BRIA)
Farida Kassim Ejaz, PhD, LISW-S
Christine Foley, BA, RN, COS-C
Lauren Borato, BS
Amanda McLaughlin, BA

CONTRIBUTOR, CHAPTER 13, CASE OF “JANE”
Georgia J. Anetzberger, PhD, ACSW

CONTRIBUTORS, EPILOGUES
Georgia J. Anetzberger, PhD, ACSW
Terry Fulmer, PhD, RN, FAAN

REVIEWER, CHAPTER 5
Charles P. Mouton, MD, MS

REVIEWER, CHAPTER 7
Farida Kassim Ejaz, PhD, LISW-S
The United States is experiencing a substantial growth in the number of adults age 65 and older and this trend is expected to continue over the next few decades. Although the focus has been on discovering ways to provide the best health care for a population in which the majority will have one or more chronic diseases, little attention has been given to the growing problem of elder abuse. Elder abuse is a worldwide problem with a varying prevalence, based on population settings, definitions, and research studies. Elder abuse is prevalent among older adults with dementia, minority populations, and marginalized populations. However, elder abuse can happen to anyone (e.g., lower or upper socioeconomic status, male or female) and in any setting (e.g., in the home, in long-term care). The National Center on Elder Abuse defines the following seven types of elder abuse: self-neglect, neglect, physical, emotional (psychological), exploitation, sexual, and abandonment.

Elder abuse, also called elder mistreatment or elder maltreatment, is highly associated with death as well as many health problems related to the abuse (e.g., depression, emotional trauma, poor quality of life). In a cost-conscious health care environment, elder abuse can significantly contribute to health care costs with incalculable costs relating to the multifaceted effects on older adults. Health care professionals are uniquely positioned to screen, detect, and intervene for elder abuse; however, a major problem is that many health care professionals lack the knowledge and skills to effectively engage in these activities. In part, this is due to a strong focus on child abuse and domestic violence among younger adults, rather than recognizing the critical issue of elder abuse. Even though these are extremely important issues, elder abuse deserves as much or more attention because of the rapidly growing older population. Up until now, there have been no distinct and comprehensive resources for nurses to guide them on how to identify
and intervene in cases of actual or potential elder abuse. Fortunately, Carol A. Miller has integrated current best available evidence and her extensive experience as a gerontological nurse to author *Elder Abuse and Nursing: What Nurses Need to Know and Can Do About It*. This book is a great resource for practicing nurses who play an instrumental role in addressing elder abuse.

This book takes a unique perspective by discussing cultural considerations, key components of physical and psychosocial assessment, and evidence-based interventions across various care settings. In addition, the exemplars presented through the stories of abused older adults will enhance critical thinking skills for easier application to clinical practice. The recognition of elder abuse is important, but just as vital is engaging in preventive measures by identifying vulnerable older adults; preventive strategies are distinctly presented in this book. The book presents the essential role of nurses related to detecting and preventing elder abuse. Elder abuse is under-recognized and under-reported, thus limiting nurses’ comprehension of the true complexity of the problem. Even though nurses are required by law to report suspected elder abuse, barriers to reporting can present an extremely challenging ethical and moral dilemma. Throughout my nursing career, I have cared for older adults with chronic kidney disease and have witnessed elder abuse, mostly in the forms of neglect and financial abuse. In 2002, although I had been a nephrology nurse for over a decade, I did not truly comprehend my essential role in identifying and intervening in situations of elder abuse until my patient shared his story. As a new nurse practitioner and member of an interprofessional health care team, I was faced with a moral dilemma that many health care professionals face when making decisions to report elder abuse of someone they have known for years.

Mr. Adams (a fictitious name) was a 78-year-old male with multiple chronic health conditions including end-stage renal disease (ESRD) who was undergoing in-center hemodialysis three times a week. The health care team (nephrologist, nurse practitioner, nephrology nurses, and social worker) had cared for Mr. Adams before he was receiving dialysis and knew him to be a strong and vibrant man who continued to work and enjoy spending time with his much younger wife (who was 57 years old), despite having the interference of thrice-weekly dialysis. This all changed after Mr. Adams fell, fractured his right hip, and underwent surgery that required rehabilitation in a skilled nursing facility. His lengthy recovery time and physical functional decline led to loss of his employment. Over time Mr. Adams, experienced further functional decline and appeared to be sad. One day he disclosed that
his wife was drinking more and he presented a situation that was consistent with emotional (psychological) abuse. The health care team met with Mr. Adams and he pleaded with them not to report the abuse. Having known him for years, the health care team made the decision to speak to his wife about receiving counseling, which she agreed to do. For a short time, things appeared to improve, but similar to other cases of abuse this did not last. Eventually, Mr. Adams was hospitalized for other health conditions; while he was hospitalized, his wife relocated to another state with all of his assets, leaving him with just the clothes on his back and his monthly Social Security checks. Mr. Adams was devastated and within 3 months he died alone in a long-term care facility instead of in the home he loved and with the wife he adored by his side.

Mr. Adams’s story provides an example of the importance of having the knowledge and skills to address actual or potential elder abuse. The health care team felt a moral obligation to Mr. Adams, so they did not report the elder abuse early enough, which led to devastating consequences. Although at the time of the initial identification of elder abuse the health care team thought they were doing the right thing, after reflecting on the situation they have disclosed regrets about the decision and have vowed that this will never happen again.

Unfortunately, it often takes a negative experience for health care professionals to realize the need to be better informed and gain the skills to take action, which was true in the previous example. Therefore, it is crucial to have a book like this to help nurses recognize elder abuse and implement appropriate interventions that can lead to the best possible outcomes. This book discusses elder abuse within the complexities of different care settings and under unique circumstances. I am extremely grateful for this book because it provides a comprehensive guide of how to address the emerging critical issue of elder abuse.

Debra Hain, PhD, ANP-BC, GNP-BC, FAANP
Associate Professor/Lead AGNP Faculty
Nurse Practitioner, Louis and Anne Green Memory and Wellness Center
Christine E. Lynn College of Nursing, Florida Atlantic University
Boca Raton, Florida
For more than four decades as a nurse and nurse practitioner, I have cared for older adults in homes, hospitals, hospice settings, a geropsychiatric program, long-term care facilities, and a variety of community-based programs. In all these settings, I have been an integral part of the lives of older adults who experienced some abuse in one or more of its many forms. Sometimes I did not recognize the abuse; sometimes I was powerless to change the situation; sometimes I reported the situation; sometimes the outcomes were not pleasant; and sometimes I was able to resolve the situation. At all times, I knew that I could at least listen to these older adults and support them, no matter how frustrated I was by the many barriers to resolving the abuse or alleviating the consequences. These situations—and the challenges inherent in them—made me keenly aware of the tremendous need for more knowledge, more services, more interventions, and more efforts toward prevention of elder abuse.

In contrast to the commonly held perception that elder abuse occurs primarily in substandard nursing homes or in high-risk domestic situations, the reality is that any older adult can become a victim of elder abuse. Studies indicate that at least 1 of every 10 older adults experiences elder abuse. Most importantly, this statistic does not account for the many other older adults who are at risk for abuse, nor does it include the larger percentage of cases that are unrecognized and unreported. Applying these statistics to health care settings, if you are a nurse who provides care to older adults, you are likely to encounter an elder abuse situation at least occasionally and probably more frequently than you realize. On a personal level, you may know an older friend, neighbor, or family member who is experiencing or has experienced elder abuse.
Elder abuse remains hidden until one of the following scenarios occurs: (a) The situation escalates to a level that requires the attention of professionals who cannot ignore its seriousness; (b) the older adult trusts a caring professional enough to share his or her story and the professional takes action to address the situation; or (c) a caring professional recognizes indicators of abuse and takes appropriate actions. A major intent of this book is to enable nurses to be the caring professionals who recognize indicators of or risks for elder abuse and intervene to prevent or address this all-too-common and very serious health problem.

Throughout this book, stories of older adults illustrate what it means to be a victim of or at risk for elder abuse. The book also describes nurses who care for older adults who are victims of elder abuse. For the most part, the accounts involve “ordinary” older adults and nurses and they represent commonly encountered nurse–client or nurse–patient situations. The nurses are not certified as “elder abuse nurses”—there is no such certification—but they are “everyday nurses” who care for older adults in all health care settings. Sometimes the nurses do not recognize the abuse or the risk of abuse, sometimes they do not know what questions to ask, sometimes they do not want to know the details, sometimes they report the abuse, other times they decide not to report, or they do not even realize that they are obligated to make a report. In some situations, the nurses feel powerless and occasionally they may even be intimidated by the perpetrators, who may also be the caregivers for the older adult. At times, nurses experience moral distress or ethical dilemmas, for example, when they are required to respect a legally competent older adult’s right to make unwise decisions that pose risks to health and safety. In these situations, they know what interventions can reduce the risks, but they are not the ones making choices.

I developed this book as a guide for nurses who care for older adults in any clinical setting, with the recognition that they encounter situations of actual or potential elder abuse among their usual clients and patients. These situations are complex and challenging and nurses have no “how-to” manual to guide their care. This book merges my extensive professional background in gerontological nursing with my long-time commitment to preventing and addressing elder abuse. While I recognize that elder abuse requires that solutions be initiated at many levels, I also recognize the essential roles of nurses in addressing elder abuse when they care for older adults. In many situations, nurses are the linchpins of the care plan. My approach in this book is to apply what is known about elder abuse to the everyday experiences of
practicing nurses. As such, it is a research-based and clinically relevant guide to what nurses need to know and can do about elder abuse.

OVERVIEW OF THE BOOK

The chapters in Part I provide background information on elder abuse as it applies to nurses in health care settings. Chapter 1 introduces the topic by describing the forms, risks, and consequences of elder abuse in various settings. Issues related to terminology are also discussed, as there is much confusion about terms. Chapter 2 discusses elder abuse by a trusted other in domestic settings. Nurses encounter this type of elder abuse when they care for older adults who live with or receive care from trusted others who neglect, abuse, or exploit them in some way. Chapter 3 describes self-neglect as a unique form of elder abuse and discusses the roles of nurses in addressing these situations. Chapter 4 provides an overview of elder abuse in long-term care facilities and it reviews responsibilities of nurses with regard to this type of abuse. Chapter 5 helps nurses develop cultural competence when caring for older adults who may be in abusive situations. This chapter also provides details about cultural considerations related to elder abuse in specific groups in the United States.

Part II describes roles of nurses in detecting and reporting elder abuse. Chapter 6 discusses legal responsibilities of nurses, including information about reporting suspected abuse. Chapter 7 helps nurses recognize indicators of elder abuse and communicate with older adults and caregivers about this complex and sensitive issue. Chapter 8 focuses on ethical issues related to elder abuse, with emphasis on dilemmas faced by nurses in clinical settings. An additional intent is to discuss self-care for nurses so they become comfortable with their professional responsibilities and personal responses when they care for older adults in abusive situations.

The chapters in Part III serve as a “how-to” guide for nurses. As such, these chapters illustrate the application of usual nursing assessment and intervention skills to unusual situations when nurses care for older adults who are in abusive or potentially abusive situations. Chapter 9 helps nurses apply assessment skills to elder abuse situations, including the following aspects: overall assessment approach, physical assessment, safety and functioning, psychosocial assessment, and caregivers and social supports. Nurses can use information in Chapter 10 to develop nursing interventions that address the following facets of elder abuse situations: overall approach, behavioral and
mental health issues, risks to safety of the older adult and others, resources within the health care settings, needs of caregivers, family dynamics, and legal issues. Chapter 11 provides comprehensive information and case examples about resources that nurses can use to address elder abuse.

The chapters in Part IV use unfolding case examples to describe nurses in action addressing elder abuse across settings. Chapter 12 illustrates roles of several nurses as they work with other professionals to address a complex domestic elder abuse situation. Chapter 13 demonstrates the multidimensional roles of Nurse Anne as she provides one-on-one care and as she participates in a multidisciplinary team discussion to address complex issues related to a self-neglecting older adult. Chapter 14 illustrates how Nurse Cathy works with members of an interprofessional team to identify risks and implement interventions to prevent elder abuse.

Part V provides an overview of financial abuse and sexual abuse as types that often involve specialized professionals and law enforcement officers. Chapter 15 provides an overview of financial abuse and describes roles of nurses in identifying and preventing this type of elder abuse. It also presents information about the important roles of health care professionals in identifying the need for a comprehensive financial capacity assessment and facilitating referrals when the need is identified. Chapter 16 discusses aspects of sexual abuse of older adults that are pertinent to nurses, including unique skills related to nursing assessment of and interventions for sexually abused older adults.

Georgia J. Anetzberger, PhD, ACSW, a nationally recognized elder abuse scholar and advocate, developed the first of the two epilogues in the book to present a vision for the future. Her hopeful perspective is rooted in 42 years of work in the field of elder abuse, including her current involvement with numerous ongoing initiatives, such as the Advisory Board for the National Center on Elder Abuse, the Steering Committee of the Elder Justice Roadmap, and the Board of Directors for the National Committee for the Prevention of Elder Abuse. Dr. Anetzberger’s epilogue concludes with a call for nurses to take action—now!—to address elder abuse.

Terry Fulmer, PhD, RN, FAAN, contributed an epilogue based on her extensive expertise and leadership in clinical, research, and policy-making roles related to elder abuse. Dr. Fulmer is nationally and internationally recognized as a leading expert in geriatrics and is best known for her research on elder abuse and neglect, which has been funded by the National Institute on Aging and the National Institute
for Nursing Research. She recaps major themes of this book and eloquently highlights the responsibilities of nurses in addressing elder mistreatment during “every touch point with our patients, our clients, our residents.”

FEATURES OF THIS BOOK

- Guides to nursing assessment and interventions that address specific forms of elder abuse
- Several types of case examples illustrating nurses in action addressing situations of elder abuse across health care settings
- Details about responsibilities of nurses in various health care settings
- Words of older adults describing their experiences and perceptions of elder abuse
- Words and thoughts of nurses describing their reflections on and perceptions of elder abuse situations
- Key Points: What Nurses Need to Know and Can Do

WALKING IN THE SHOES OF NURSES CARING FOR OLDER ADULTS

On a personal/professional note: I have walked in the shoes of nurses who have encountered elder abuse situations and experienced the frustrations of caring for older adults who are at risk for or exhibit the serious consequences of elder abuse, neglect, or self-neglect. From this perspective, I understand the frustrations of being able to anticipate predictable consequences of actions taken or not taken that foster these situations, but being helpless to prevent the consequences. With great sadness, I recall my visit to an older couple who were socially and culturally isolated and overwhelmed with the burden of mutual caregiving due to their progressively declining health problems. I had reported them to adult protective services, but professional actions were too little and too late, and I was troubled when I watched the evening news report that the husband had beaten his wife with a tire iron. Although this experience occurred 30 years ago, I still have vivid memories of my visit to them and the evening news report several days later—and I still have questions about what could have been done to prevent this devastating outcome. I would like to believe that this and other types
Preface

of elder abuse no longer occur, but I know too well that much progress needs to be made in preventing elder abuse. On a hopeful note, however, I am optimistic about the many efforts of direct-care professionals, administrators, scholars, policy makers, and funding initiatives that are currently underway. My overriding hope is that information in this book will empower nurses to make a major difference in the lives of older adults who are in actual or potential elder abuse situations. Echoing the calls to action articulated by Georgia Anetzberger and Terry Fulmer in the epilogues, I call on nurses to become knowledgeable about elder abuse so they can competently and comfortably apply their nursing skills to caring for older adults who all too commonly are at risk for or experiencing elder abuse.

Carol A. Miller
ACKNOWLEDGMENTS

On a personal level, I am most grateful for the boundless support of my main cheerleader, Pat Rehm, whose mantra for me has been “keep writing.” The support and encouragement from my family has been invaluable as I have developed this book. On a professional level, I am especially grateful for the support, guidance, and wisdom provided by Georgia J. Anetzberger and Elizabeth Nieginski from inception to completion of the book. I greatly appreciate Georgia’s multidimensional expert consultation and contributions and Elizabeth’s ongoing expertise and advice as my editor at Springer Publishing Company. Just as it takes a team to address elder abuse, it takes a team to develop a book, and I appreciate all who have contributed to this process.
In 1966, two British physicians applied the term *senile breakdown syndrome* to describe “a group of individuals who cease to maintain the standards of cleanliness and hygiene which are accepted by their local community” (Macmillan & Shaw, 1966, p. 1032). In the United States around that same time, the term *social breakdown syndrome* was used to describe behavioral manifestations of squalor, neglect of hygiene and personal environment, and refusal of assistance (Gruenberg, Brandon, & Kasius, 1966). Currently in the United States, self-neglect is considered a unique form of elder abuse, even though these situations rarely involve “abuse” per se and they also occur in younger adults.

During the past several decades, nurses, physicians, and other health care professionals have addressed self-neglect in many ways, including as a nursing diagnosis and a geriatric syndrome. This chapter describes self-neglect as a unique type of elder abuse with emphasis on aspects that are most relevant to addressing the needs of self-neglecting older adults in health care settings. Ethical issues related to self-neglect are addressed in Chapter 8, and aspects of nursing assessment and interventions are discussed in Chapters 9 and 10. Chapter 13 presents an unfolding case example illustrating responsibilities of nurses in addressing self-neglect in clinical practice.
DEFINITIONS AND SCOPE OF SELF-NEGLECT

The National Adult Protective Services Association (n.d.) defines self-neglect as “self-care and living conditions that are potentially hazardous to the health, safety or well-being of adults.” This is one of at least 10 widely recognized definitions that typically include the following key concepts:

- Persistent lack of essential self-care (e.g., inattention to personal hygiene, seriously unkempt appearance)
- Persistent lack of cleanliness in the personal environment
- Lack of essential services and social support
- Personal behaviors that can lead to endangerment

In general, self-neglect is an umbrella term applied to a broad range of situations that involve a combination of personal behaviors and conditions within the person’s environment that are actually or potentially harmful to the person or others. On the individual level, self-neglect includes a broad spectrum of health-related and self-care behaviors, ranging from nonadherence to health promotion recommendations at one end to self-abusive and life-threatening behaviors at the most serious end. On the environmental level, self-neglect situations range from minor disrepair of housing to squalor and life-endangering conditions, such as fire hazards and disease-promoting infestations. In communities, self-neglect is a major concern when the situation threatens the health and safety of others.

The majority of self-neglecting older adults live alone, but self-neglect can occur when two or more people live in unsafe conditions and have unmet needs for basic care. For example, an older couple who both have dementia may live unsafely in self-neglecting conditions in their own home. Self-neglect also applies to caregivers who neglect their health needs because they devote their time and energy to caring for someone else. In addition, elder abuse scholars currently are addressing the occurrence of self-neglect in semi-independent settings, such as assisted living facilities.

SELF-NEGLECT AS A UNIQUE FORM OF ELDER ABUSE

Although self-neglect is not defined specifically in all state elder abuse statutes, adult protective service agencies in all states accept referrals and investigate self-neglect. In reality, self-neglect is the most frequently
encountered form of elder abuse addressed by adult protective service agencies. Manifestations of self-neglect are similar to those of neglect by caregivers; however self-neglect occurs in the absence of identifiable caregivers. Box 3.1 summarizes commonalities and differences between self-neglect and other forms of domestic elder abuse.

**BOX 3.1  Self-Neglect and Other Forms of Domestic Elder Abuse: Commonalities and Differences**

Common characteristics of self-neglect and other forms of domestic elder abuse
- Social isolation is often a contributing factor.
- The situation can develop either intentionally or unintentionally.
- A vulnerable older adult is perceived as needing protection from self or others.
- The older adult is perceived as needing assistance and lacking reliable and appropriate support services.
- Questions arise about the capacity of the older adult to accept or refuse assistance.
- Cultural norms of society affect perceptions of and approaches to the situations.
- Reported cases represent only the “tip of the iceberg” of suspected actual cases.
- If the situation does not pose threats to others, such as family, neighbors, or bystanders, it is more difficult to impose services.

Characteristics unique to self-neglect
- The danger of harm arises from the individual rather than from outsiders.
- Caregivers are not available as acceptable resources.
- Most self-neglecters do not perceive problems within their situation.
- Protective services can be imposed more readily when the person is being victimized by another person.
- Imposition of services changes the person’s independence and threatens the right to be autonomous, independent, and to live in any chosen lifestyle.
RISK FACTORS FOR SELF-NEGLECT

Self-neglect occurs within the context of interactions among several risk factors in the older adult and his or her social and physical environments. Typically, older adults who become self-neglecting experience a combination of (a) physical disability or medical conditions, (b) cognitive impairments or mental illness, and (c) inadequate social supports. Specific health conditions identified as risks for self-neglect include diabetes, arthritis, dementia, depression, cardiovascular disorders, nutritional frailty, and bladder/bowel incontinence (Dyer, Goodwin, Pickens-Pace, Burnett, & Kelly, 2007; Ernst & Smith, 2011). Decline in physical function is associated not only with an increased risk for but also with greater seriousness of self-neglect (Dong et al., 2010). Elder abuse scholars increasingly are focusing on cognitive skills related to executive function as a condition that underlies all or most self-neglect situations, as discussed in the next section. Some psychosocial conditions associated with self-neglect include alcoholism, poor family relationships, and experiences of loss, grief, or abandonment. Table 3.1 lists some of the conditions in older adults that are associated with increased risk for self-neglect.

As with other types of elder abuse, social isolation and lack of social supports create risks for self-neglect. Social isolation occurs partially because self-neglecting older adults are likely to live alone and have little contact with family or friends. Lack of social supports occurs when the older adult does not use available services or when services are not available. Although self-neglecting older adults are often described as refusing services or resisting care, lack of care is sometimes rooted in the person’s inability to perceive his or her own needs, as is common in these situations. In other situations, the person does recognize the need and would be willing to accept services, but acceptable services are not available. Analysis of data from adult protective service cases in Texas concluded that a lack of public social and health care services is a major risk for self-neglect, particularly in poor rural areas (Choi, Kim, & Asseff, 2009). These situations may be most amenable to resolution if service providers, including health care professionals, can identify acceptable social supports, as discussed in Chapter 11.

Alcoholic . . . drank all my life . . . you couldn’t get in or out, empty beer cans all over the place . . . used to accumulate . . . sold my saxophone for drink years ago. (Day, Leahy-Warren, & McCarthy, 2013, p. 84)
### TABLE 3.1 Conditions That Increase the Risk for Self-Neglect

<table>
<thead>
<tr>
<th>OLDER ADULT CONDITION</th>
<th>RELATED RISK FOR SELF-NEGLECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disability or impairment</td>
<td>Decreased ability to care for self and personal environment</td>
</tr>
<tr>
<td>Progressive or complex medical conditions</td>
<td>Potential for poor management leading to worsening of conditions (e.g., unmanaged hypertension leading to stroke)</td>
</tr>
<tr>
<td>Vision or hearing impairment</td>
<td>Social isolation, diminished ability to care for self and personal environment</td>
</tr>
<tr>
<td>Depression</td>
<td>Low self-esteem, lack of motivation, social isolation, decreased interest in self-care, self-harm, or suicidal thoughts or actions</td>
</tr>
<tr>
<td>Dementia</td>
<td>Cognitive changes affecting memory and executive function gradually affect all aspects of self-care and ability to remain independent</td>
</tr>
<tr>
<td>Stressful major life event</td>
<td>Grief, depression, social isolation</td>
</tr>
<tr>
<td>Excessive use of alcohol</td>
<td>Cognitive impairment, depression, malnutrition, self-injury, social isolation, nonadherence to medical care, avoidance of medical care to avoid detection</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>Social isolation, phobias, difficulty adjusting to change</td>
</tr>
<tr>
<td>Delusions or paranoia due to mental illness</td>
<td>Social isolation, increased resistance to assistance, lack of insight, hoarding behaviors, distrust of outsiders, avoidance of medical care</td>
</tr>
<tr>
<td>Loss of familiar caregivers</td>
<td>Grief, depression, resistance to using new or outside resources</td>
</tr>
<tr>
<td>Low income status</td>
<td>Lack of financial resources for services</td>
</tr>
<tr>
<td>Low health literacy</td>
<td>Difficulty managing medical care</td>
</tr>
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COGNITIVE CHARACTERISTICS IN RELATION TO SELF-NEGLECT

Cognitive characteristics of self-neglecting older adults need to be considered from two perspectives: (a) as conditions that increase the risk for self-neglect, and (b) as a major consideration with regard to the older adult’s capacity for self-determination and right to refuse services. Ethical concerns are associated with cognitive and mental health characteristics because self-neglect situations typically involve questions about the older adult’s capacity for self-care and self-protection and both of the following conditions also exist: (a) The person requires assistance with meeting basic needs, and (b) essential and acceptable supports are not being provided. When services are offered but the person refuses to accept them, ethical issues must be addressed in relation to the person’s right to live in whatever way he or she chooses, regardless of consequences for the individual.

Cognitive Deficits as a Risk for Self-Neglect

Executive function has been identified as the cognitive skill that is most strongly correlated with self-care abilities of older adults referred to adult protective services for self-neglect (Schillerstrom et al., 2013). Executive function refers to a cluster of “master” cognitive processes that control, regulate, and manage all other cognitive processes. In everyday life, these processes help people focus attention, form goals, plan actions, self-monitor, solve problems, make decisions, and initiate and carry out goal-directed behaviors. A small degree of executive dysfunction is normal for all adults, both chronically and under stressful conditions. For example, under distracting conditions, it is usual to have difficulty focusing attention on tasks at hand. More serious degrees of executive dysfunction are often associated with pathologic conditions, such as dementia, depression, Parkinson’s disease, and mental illnesses. Executive dysfunction can also be caused by medical conditions, including treatable ones, such as nutritional deficiencies. Table 3.2 summarizes manifestations of executive dysfunction that can lead to self-neglect, particularly in people who live alone and do not have adequate support resources.

Cognitive Function in Relation to Capacity to Refuse Services

Determination of a person’s capacity to refuse services is based on a comprehensive assessment of cognitive skills related to decision making, as reviewed in detail in Chapter 9. In self-neglect situations,
the assessment focuses on the person’s abilities related to self-care and self-protections with emphasis on whether the person understands his or her circumstances and accepts appropriate steps to correct problems (Reyes-Ortiz, Burnett, Flores, Halphen, & Dyer, 2014). Box 3.2 presents key points of a brief checklist for determining capacity in self-neglect situations, which was developed by the Texas Elder Abuse and Mistreatment Institute (Reyes-Ortiz et al., 2014). This is not a substitute for a comprehensive assessment, but can be used as a screening tool in clinical settings.

**TABLE 3.2 Executive Dysfunction as a Risk for Self-Neglect**

<table>
<thead>
<tr>
<th>MANIFESTATION OF EXECUTIVE DYSFUNCTION</th>
<th>EXAMPLE IN DAILY LIFE AS A RISK FOR SELF-NEGLECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to plan a task</td>
<td>Not shopping for groceries necessary for food preparations</td>
</tr>
<tr>
<td>Difficulty initiating a task</td>
<td>Not engaging in personal care activities, such as bathing or grooming</td>
</tr>
<tr>
<td>Poor problem solving</td>
<td>Repeatedly falling in a cluttered environment but not removing obstacles</td>
</tr>
<tr>
<td>Difficulty organizing information</td>
<td>Having bills and papers piled in numerous places and not knowing how to sort them</td>
</tr>
<tr>
<td>Inability to adapt to changing conditions</td>
<td>Living in a very cold environment and not figuring out who to call to fix the furnace</td>
</tr>
<tr>
<td>Impaired working memory</td>
<td>Not taking medications or going to medical appointments</td>
</tr>
<tr>
<td>Impaired self-monitoring</td>
<td>Driving a car unsafely</td>
</tr>
<tr>
<td>Impulsivity (i.e., impaired ability to think before acting)</td>
<td>Walking outside without being dressed appropriately for the weather</td>
</tr>
</tbody>
</table>

If you infringe on our dignity . . . it’s a difficult balance. Hopefully it’s not a rat-ridden house or whatever. There are extremes that somebody will have to intervene, but I think sometimes people rush in and think “What’s best for this lad; oh, residential care!” They don’t sit down and ask “What do you think?” (Taylor, Killick, O’Brien, Begley, & Carter-Anand, 2014, p. 234)
### BOX 3.2 Checklist for Determining Capacity in Self-Neglect Situations

**Does the Person Understand His or Her Circumstances?**

Despite adequate resources, the person . . .

- _______ fails to perform an ADL* . . .
- _______ fails to perform an IADL** . . .
- _______ is exposed to an unsafe, unsanitary, or inadequate housing condition . . .
- _______ has suffered abuse, neglect, exploitation, or self-neglect . . .

. . . and does not understand this fact

**Is the Person Failing to Self-Care and Self-Protect?**

Despite adequate resources, the person . . .

- _______ is failing to perform an ADL . . .
- _______ is failing to perform an IADL . . .
- _______ is exposed to an unsafe, unsanitary, or inadequate housing condition . . .
- _______ has suffered abuse, neglect, exploitation, or self-neglect . . .

. . . and does not take appropriate steps to correct the problem

*ADL, activity of daily living: toileting, dressing, grooming, ambulation, bathing.

**IADL, instrumental activity of daily living: shopping, food preparation, housekeeping, laundry, taking medications appropriately, using a telephone, arranging for transportation, handling finances.

Adapted from John M. Halphen for the Texas Elder Abuse and Mistreatment Institute, published in Reyes-Ortiz, Burnett, Flores, Halphen, and Dyer (2014).

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### CHARACTERISTICS OF ENVIRONMENTS ASSOCIATED WITH SELF-NEGLECT

Self-neglect typically occurs in a personal environment of negligent and often unsanitary or even dangerous conditions. When conditions in the living space, house, and exterior surroundings are so unsanitary that they pose a danger to the health or safety of the occupant or others, the term *squalor-dwelling* is used (Aamodt, Terracina, &
Schillerstrom, 2015). Iris, Conrad, and Ridings (2014) developed an evidence-based scale for indicators of self-neglect, including clusters associated with physical and personal living conditions. Box 3.3 summarizes some of these indicators in the context of considerations related to environments.

**HOARDING AS AN ASPECT OF SELF-NEGLECT**

Although many people lightly refer to “hoarding” when they stock their shelves with extra groceries or purchase duplicate items that are

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**BOX 3.3 Questions to Consider When Assessing the Environment in Relation to Self-Neglect**

Does the Personal Environment . . .

- . . . have evidence that the older adult is eating spoiled food?
- . . . have odors or substances that raise concerns (e.g., urine, garbage, spoiled food, human or animal feces, vermin)?
- . . . have an accumulation of garbage or items that presents a safety hazard?
- . . . lack access to safe, sanitary, and operable toileting and bathing facilities?
- . . . lack safe and operable supplies and equipment for food preparation (e.g., stove, refrigerator, sink with running water)?
- . . . have risks for fire hazards or lack smoke detectors?
- . . . have evidence of hoarding?
- . . . lack at least one clear path for emergency evacuation?
- . . . have pets that are excessive in numbers or not maintained?
- . . . lack adequate lighting?
- . . . lack a functional telephone?
- . . . lack the ability to maintain a safe and comfortable temperature?
- . . . lack basic functional utilities?

Adapted from Iris, Conrad, and Ridings (2014).
not needed immediately, in the context of a clinical diagnosis, hoarding is characterized by the following:

- Persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions
- The accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible
- The presence of significant personal distress or impairment in social, occupational, or other important areas of functioning
- Lack of insight
- Little or no motivation for change
- Difficulty or impossibility in maintaining a safe environment for self and others

Hoarding behaviors may occur as a manifestation of mental illnesses, such as schizophrenia or obsessive-compulsive disorder, in which cases the behaviors typically begin during early adulthood and gradually become more disabling. In older adults who become self-neglecting, hoarding behaviors are often associated with dementia or late-life depression. In these situations, the hoarding behaviors may arise from deficits in executive function that affect organizational abilities and awareness, as described in Table 3.2. Hoarding behaviors can lead to health problems and unsafe conditions, such as risks for falls and fires. Additional consequences that commonly occur in self-neglect situations include impaired daily functioning, food contamination, unsanitary environment, social isolation, impaired quality of life, and high levels of family frustration.

Animal hoarding is described as a public health problem characterized by a combination of the following conditions:

- The possession of more than the typical number of companion animals
- The inability to provide basic care, which can lead to illness, starvation, and death of the animals
Denial about one’s inability to provide care

Lack of insight about the effects of the situation on the occupants, animals, and household environment (Patronek, 1999)

As with other types of hoarding, animal hoarding is a chronic condition that may progress from mild to severe. Adult protective service agencies cite compelling evidence of a strong association between animal hoarding and self-neglect by the animal hoarder (Nathanson, 2009). In contrast to object-hoarding environments, the vast majority of animal-hoarding households usually involve squalor and major personal and public health hazards (Frost, Patronek, & Rosenfield, 2011).

PERSPECTIVES OF OLDER ADULTS WHO BECOME SELF-NEGLECTERS

Qualitative studies of older adults identified as hoarders or self-neglecters provide insight into the broader social aspects of self-neglecting older adults. For example, a dominant theme identified through interviews with 16 self-neglecting elders in Israel is that their current conditions of self-neglect were “anchored in cumulative experiences of frequent transitions, the inability to put down roots, a sense of isolation, attempts to acclimatize and to survive alongside personal losses and traumatic life circumstances” (Band-Winterstein, Doron, & Naim, 2012, p. 113). Box 3.4 describes perspectives of five older adults identified as self-neglecting. Similarly, interviews with eight self-neglecting older adults in Ireland identified common experiences of multiple hardships during early life, along with themes of social isolation, vulnerability, frugality, and service refusal (Day et al., 2013).

AVOIDING STEREOTYPES ABOUT SELF-NEGLECTING OLDER ADULTS

As with other types of elder abuse, it is imperative to avoid stereotypes. This is particularly pertinent with regard to the older adult’s acceptance of services. When service providers and health care professionals encounter a self-neglect situation, they may be inclined to judge the person as noncompliant and resistant. Many times, however, self-neglecting older adults lack awareness of their situation due to cognitive impairments and they are receptive to interventions if
BOX 3.4 Older Adults Describe the Life Course of Their Self-Neglect

Adina, age 68, whose self-neglect is manifest in hoarding, slovenly appearance, dirty clothes, and unclean and neglected surroundings, described her transition to self-neglect as a crisis stage filled with suffering:

I worked cleaning houses for years . . . and when I was 50, I had a crisis, depression and that, you know, all sorts of things like that and then I asked to be hospitalized . . . that was the outcome of everything I’d seen in my childhood . . . all sorts of things that children shouldn’t see . . . I was there about two months and came home . . . I rest, I read, I do crosswords, I try but . . . I cut myself off from my sisters a bit, and I’m sorry about that, and also from my daughter a bit, and from the grandchildren.

Anna, age 68, described her “normal” life and how it changed due to poor health and declining physical capability:

I started suffering from shortness of breath . . . and the house wasn’t worth anything in any case. I had plans and all sorts of nice things and carpets and all that, and the cats just about destroyed it all . . . and I want to add another sand box because it smells and the neighbors complained . . . I say I’ll do it, but I don’t do it, as I haven’t the strength . . . my house has turned into a shed . . . this morning, I swept the floor and I wiped over here so that you wouldn’t be repulsed . . . and I walk around in the dust and go up to bed and dirty the bed.

Shoshana, age 65, described her reaction to offers of support:

I’m not willing to leave here. They say to me, “You’re disabled, you need to live on the ground floor.” I said, “I like this place. I like this environment. Why should I move? All my memories are here.” . . . The caregiver throws away my newspapers. I got angry with her. She clears me out of everything . . . and she was supposed to help me to shower today, but she was too busy throwing things away . . . if I don’t look out for myself, then who will look out for me?”

Martha, age 90, who was aware that others perceived her as “crazy,” described her positive traits:

That’s my personality, I’m not angry, I don’t do anything bad . . . I worked throughout my whole life . . . I always had something else to keep me busy . . . I didn’t want another woman to help me . . .
social service or health care professionals approach the topic nonjudgmentally and engage the older adult in problem solving. Similarly, service providers and health care workers may assume that the person does not have the capacity for making appropriate decisions. In these situations, it is imperative to obtain an evaluation of capacity, which is best performed in the context of a comprehensive geriatric assessment. It is also important to consider that services are not being provided because there are no appropriate, acceptable, and affordable ones available. In addition, cultural influences, as discussed in Chapter 5, need to be considered as a factor that can affect both the perception of self-neglect situations and the acceptance of services.

**CONSEQUENCES OF SELF-NEGLECT**

Although autonomous adults have the right to live in whatever way they choose, self-neglect situations can have serious consequences for the individual, for his or her family and friends, for the surrounding community, for health care providers and services, and sometimes for the welfare of numerous animals. An overriding concern related to consequences is the effect on quality of life for the self-neglecting older

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**BOX 3.4 Older Adults Describe the Life Course of Their Self-Neglect (continued)**

know why I don’t tell anyone about the way I live; maybe they’ll think that I’m a crazy woman . . . thank God I don’t have Alzheimer’s . . . I’m scared of dying, it’s true, I think just like everyone else.

Nehema, age 83, described herself as a compulsive hoarder with an unkempt appearance and living in a filthy environment, but perceived herself as the owner of valuable assets:

I think that every human being has life experience, because everyone has been through something . . . you know already that my soul stays the same even at my age. I’m happy with myself and I know that all beginnings also have an end but I don’t think about it. I feel good so I’m happy . . . this is my empire.

adult, which should be the main focus of all involved. This is perhaps the most challenging aspect of self-neglect, as each person involved may define quality of life differently. For self-neglecting older adults, quality of life may depend on preservation of their privacy, independence, and right to choose their living arrangements. For health care providers, quality of life for self-neglecting older adults typically involves minimal standards of personal care and health-related behaviors to prevent serious illness or premature death. For self-neglecters who are animal hoarders, quality of life may be intertwined with relationships with animals; however, the welfare of the animals also needs to be considered.

Data from the Chicago Health and Aging Project cite the following health consequences associated with self-neglect:

- An independent risk factor for death, with a 16-fold increased risk in confirmed severe cases (Dong et al., 2009)
- An independent risk factor for hospitalization (Dong, Simon, & Evans, 2012a)
- Increased 30-day readmissions to hospitals, independent of concomitant medical or social conditions (Dong & Simon, 2015)
- Increased use of hospice and shorter time with hospice before death (Dong & Simon, 2013)
- Substantially higher annual rate of emergency department visits (Dong, Simon, & Evans, 2012b)

Even aside from the consequences on human lives, with the current emphasis on preventable hospitalizations, self-neglect deserves attention as a contributing condition to cost and quality of care.

In addition to being associated with financial consequences for health care systems, self-neglect is associated with consequences for health care providers who are frustrated by their inability to provide effective care. Self-neglect situations often involve ethical dilemmas for nurses, physicians, and other health care providers when they are faced with situations in which legally competent adults engage in behaviors that pose risks to their health. Lastly, home care nurses and other health care providers who perform home visits may be exposed to personal risks when they are required to provide care in an environment that presents risks to health.

Many self-neglecting older adults are socially isolated; however, family and friends who maintain emotional or social connections experience consequences such as distress, frustration, and sadness about the situation. In addition, self-neglect situations involving unsanitary
conditions often have consequences for neighbors or apartment residents. For example, infestations of fleas or roaches may affect adjacent apartments and garbage-strewn environments may attract disease-carrying rodents to the neighborhood. Sometimes, these situations involve life-threatening risks for others, as when irresponsible smoking behaviors cause risks for fires.

**SELF-NEGLECT AS A CONCERN FOR HEALTH CARE PROVIDERS**

For many decades, social service workers and health care providers have addressed self-neglect and hoarding in community-based settings, often in conjunction with adult protective service workers. Physicians, nurses, and other health care professionals have many roles in addressing health-related aspects of self-neglect, as discussed briefly in this section and more comprehensively in Parts II and III of this book. Attention of health care providers is warranted, particularly with regard to management of medical conditions due to nonadherence to recommended treatments. For example, nonadherence with medications is strongly associated with lower functional status and increased risk for self-neglect. One study found that 90% of 100 older adult self-neglecters did not take at least one medication between 80% and 110% of the number of prescribed times, with the mean number of medications that were nonadherent being 3.4 (Turner, Hochschild, Burnett, Zulfiqar, & Dyer, 2012). Although nonadherence with recommended treatments is common among all adults, when noncompliant behaviors cause serious health consequences and there are questions about the person’s decision-making capacity, then this may be considered as self-neglect. Another health-related aspect of self-neglect is the common occurrence of nutritional problems, including vitamin deficiencies, malnutrition, and dehydration.

Physicians have addressed medical consequences of self-neglect as a geriatric syndrome. For example, Pavlou and Lachs (2006) reviewed 54 studies and identified the following characteristics indicative of self-neglect as a geriatric syndrome:

- Its multifactorial etiology
- Its clear and independent association with increased mortality
- The fact that two other geriatric syndromes (cognitive impairment and depression) are risk factors for self-neglect

Two years later, these two physicians cited self-neglect as a “growing epidemic” that has profound health and public policy implications for
an aging society. They further stated that “physicians of all types will be increasingly called upon to care for these patients, who present a variety of vexing medical, medico-legal, and ethical challenges for which training has not yet prepared them” (Pavlou & Lachs, 2008, p. 1841).

In 2006, three nurses proposed that self-neglect can be designated as a new NANDA nursing diagnosis because self-neglect “presents conceptual, identification, and intervention problems for nurses, health care workers, and for medicolegal systems across settings and in many countries” (Gibbons, Lauder, & Ludwick, 2006, p. 10). The approved NANDA definition of Self-Neglect is “a constellation of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being” (Herdman, 2012, p. 254). Defining characteristics of self-neglect are inadequate personal hygiene, inadequate environmental hygiene, and nonadherence to health activities. In clinical settings, nurses address self-neglect in relation to the following:

- Adherence to prescribed treatment for chronic conditions, such as medication management
- Functional impairments
- Cognitive function and mental health conditions
- Risks for falls and other safety concerns
- Social conditions that create risks, such as lack of appropriate and acceptable support services

Nursing interventions for self-neglecting older adults focus on concomitant conditions, such as functional limitations, self-care deficits, cognitive impairment, and unmanaged or poorly managed medical conditions.

**NURSING PERSPECTIVES ON SELF-NEGLECT**

Nurses in home care settings address self-neglect not only on a long-term basis but also in the context of the personal environment of the self-neglecting older adult. Interviews with 16 registered nurses providing home care services in a rural area in North Carolina identified several themes related to nursing perceptions of self-neglecting older adults, as summarized in Box 3.5. A dominant theme with particular implications for nursing is that “self-neglect was the ‘normal’ for these individuals, with clients conducting themselves as if self-neglecting behaviors were ordinary” (Johnson, 2015, p. 34).
### BOX 3.5 Home Care Nurses Describe Their Experiences With Clients Who Are Self-Neglecting

**Armored:** Nurses viewed self-neglecting people as “shielding” themselves as if to protect them from something or someone.
- “It becomes their normal and they just don’t see it as being odd or out of the ordinary.”
- “They viewed us as an invasion into their homes, their privacy, their independence.”
- “When somebody chooses to live off the grid you can’t impose what you consider normal on them, because for this that is their normal.”

**Psychological Derivation:** Nurses attributed self-neglect behaviors to psychological reasons, such as dementia, depression, or undiagnosed mental illness.
- “I’m thinking, wow. There’s something wrong with someone who doesn’t freak out when they see and acknowledge verbally that there are bugs in their wound.”
- “There was probably a lot of deep rooted issues that she has never dealt with.”

**Secluded:** Clients were “loners” who either chose to isolate themselves, had families who effectively excommunicated them, or were isolated by circumstances such as death of a spouse.
- “The times I’ve seen the adult children come to visit it’s always with their sense of disgust and they need to get out of there. There’s not a good relationship.”
- “They shut lots of folks out.”
- “There’s usually some type of tension between them. Either they don’t talk to the adult children, or they visit infrequently.”

**Nonconformity With Self-Care Conventions:** Clients profoundly neglected their personal care or care of their environment.
- “Hair was unkempt, dirty. Nails were outgrown with dirt underneath. Some were broken half off. . . . She had no motivation getting a bath. I could tell by her teeth that she hadn’t maintained herself even as far as daily brushing.”
- “If they have incontinence episodes, sometimes they don’t clean themselves up completely, or sometimes they don’t clean themselves up at all.”

(continued)
NURSING INTERVENTIONS RELATED TO SELF-NEGLIGENCE

Self-neglect as a unique form of elder abuse is perhaps most pertinent to nursing care across all clinical settings because nurses have numerous opportunities to address contributing factors. Sometimes relatively simple measures, such as connecting a socially isolated older adult to available community resources, can be effective in preventing the development or progression of self-neglect situations. In addition, nurses can use a wide range of nursing skills to address nonadherence to interventions for chronic conditions. Also, nurses have essential roles in addressing executive dysfunction as a common contributing condition in self-neglect situations. For example, nurses can facilitate assessment of cognitive function, assure that treatable causes of cognitive impairment are identified and managed, and assure that interventions are implemented to improve the older adult’s cognitive function. Similarly, nurses have essential roles in addressing functional limitations, both directly in care plans and indirectly through referrals for rehabilitation therapists.

Nurses address self-neglect not only through nursing assessments and interventions related to contributing conditions, but also as members of interdisciplinary teams addressing the broader context of each unique self-neglect situation. Finally, in all situations of self-neglect, nurses have opportunities to assure that the rights of the older adult are respected and that the person’s capacity is assessed appropriately.

BOX 3.5 Home Care Nurses Describe Their Experiences With Clients Who Are Self-Neglecting (continued)

• “One case I can remember in particular, there was just roaches everywhere and the man had had his scalp literally like lifted away. I think the incision was like 32 centimeters long. And then when you peeled the scalp back he had roaches on there. And you know his wife picked up that medicine box and went over there and slammed it on the counter and the roaches went running everywhere . . . I would be flipping out if I saw a roach at my house. But a roach crawling on them is not a big deal.”

Adapted from Johnson (2015). Used with permission.
These aspects require sensitivity to cultural values and often involve ethical issues, as discussed in Chapters 5 and 8.

**KEY POINTS: WHAT NURSES NEED TO KNOW AND CAN DO**

- In the United States, self-neglect is the most frequently encountered form of elder abuse addressed by adult protective service agencies.
- Risks for self-neglect include physical disability or medical conditions, cognitive impairment or mental illness, and inadequate social supports.
- Cognitive characteristics are considered in relation to self-neglecting older adults from two perspectives: as risks for self-neglect, and as a major factor in determining the older adult’s capacity for decision making.
- Hoarding and self-neglect typically involve risks to health and safety within the person’s environment.
- Self-neglect is a concern for health care providers with respect to individual older adults and the consequences affecting other people and broader environments.
- Nurses have numerous roles in addressing conditions that contribute to self-neglect.

**REFERENCES**


3 Elder Abuse in Domestic Settings: Self-Neglect


Elder abuse situations are similar to chronic health conditions in the following respects: (a) Risk factors can usually be identified, (b) the condition develops gradually and initially it may be “asymptomatic” or unobservable to others, and (c) the situation often entails intermittent exacerbations that require medical attention. In other respects, elder abuse situations differ significantly and require nurses to apply assessment skills in unique ways, as in the following aspects:

- Physical findings can often be attributed to other causes with only the most blatant manifestations being unique to elder abuse.
- Assessment of safety has unique characteristics, including identification of immediate or even life-threatening risks, particularly for older adults who live in community settings.
- Situations of elder abuse often involve some element of resistance from the older person and/or caregiver(s).
- Nurses and other health care professionals are responsible for determining whether the situation warrants a report.
- Assessments by nurses and other health care professionals may be essential for determining whether legal interventions are appropriate or necessary for protection of the older adult.

An additional unique aspect in home and community settings is that nurses may be viewed as a threat rather than as a help, and an initial challenge may involve gaining access and obtaining adequate
and accurate information. Also, risks to the nurse’s personal safety must be assessed, especially when home visits involve contact with a known or suspected perpetrator.

Elder abuse situations challenge nurses to rely on good assessment skills and all levels of nursing knowledge, including intuitive knowing. The purpose of this chapter is to help nurses use assessment skills to identify older adults who are at risk for elder abuse, as well as those who are in abusive situations. Some risks can be addressed through usual nursing interventions, as discussed in Chapter 10, whereas resolution of actual elder abuse situations often requires the involvement of specialized multidisciplinary resources, as discussed in Chapter 11.

In brief, unique aspects related to detection of elder abuse are as follows: (a) putting the pieces together and (b) raising questions about assessment findings that may be indicators of an abusive situation. The following dimensions of nursing assessment in the context of elder abuse are discussed in this chapter: physical assessment, safety and functioning, psychosocial assessment, and assessment of family caregivers and support resources. The intent is to apply usual assessment skills to nursing assessment of older adults in abusive or potentially abusive situations. Nurses can use the information in Box 9.1 as an overall guide to aspects of nursing assessment that are unique to elder abuse.

**PHYSICAL ASSESSMENT**

Key indicators of neglect, self-neglect, physical abuse, and sexual abuse can be identified through routine physical assessments. For example, the Centers for Medicare & Medicaid have mandated nursing assessment of skin changes for detection of pressure ulcers; this information can be useful for identifying indicators of neglect or self-neglect. At the same time, skin assessment provides essential information about bruises, which can be a major indicator of physical abuse by trusted others. Another assessment aspect within the scope of nursing is identification of indicators of dehydration, malnutrition, and untreated or poorly managed medical conditions. Although these conditions develop for many reasons, they are also strongly associated with many types of elder abuse. A guiding principle related to physical signs is that health care providers who discover physical injuries during the course of an examination should be mindful of elder abuse as...
BOX 9.1 Guide to Nursing Assessment Related to Elder Abuse

Provide an environment conducive to assessment
- Assure privacy for one-on-one assessment of the older adult
- Assure as much comfort for the older adult as possible
- Use communication skills to elicit information (discussed in Chapter 7)
- Consider cultural dimensions of elder abuse (discussed in Chapter 5)

Identify indicators
- Although no diagnostic test or physical sign is specific for elder abuse, good assessment skills uncover clues to elder abuse
- Assess each potential indicator within the broader context of the older adult’s health, functioning, and overall situation
- Potential indicators of elder abuse that are identified during usual nursing assessments include bruises, fractures, malnutrition, dehydration, pressure ulcers, and evidence related to activities of daily living
- Assessment of safety is essential for identifying the immediacy and type of interventions
- Because elder abuse is often cumulative and progressive, it is important to identify risks before a situation reaches the level of reporting as a suspected case

Document pertinent findings
- Document all findings that can be signs of or risks for elder abuse
- Use evidence-based information to support conclusions that bruises are likely to be inflicted by others rather than accidental (e.g., figure, inside front cover)
- Document skin abnormalities on figures showing both the front and back of the body
- Document discrepancies between different sources, or between explanatory statements and objective evidence
- Document caregiver behaviors that are generally regarded as “red flags” for abusive situations (e.g., caregiver refuses to allow privacy, lack of concern about significant findings)
- Document changes in behavior of the older adult when the caregiver is or is not present (e.g., unwillingness to talk when the caregiver is present, signs of relief when caregiver is not present)
- Review patient records for indicators that were identified during previous encounters and consider these in relation to current assessment information
- Document reports to or activities of adult protective services
a cause. Alternatively, providers who suspect any type of elder abuse should look for signs (Gibbs, 2014).

Any of the following conditions can be indicators of abuse, neglect, or self-neglect: leg ulcers; pressure ulcers; dependent edema; poor wound healing; burns from stoves, cigarettes, or hot water; and bruises, swelling, or injuries from falls, especially repeated falls. More than one of these indicators at the same time, or over a period of time, should raise high levels of suspicion about abuse or neglect. To detect physical abuse, look for evidence of injury caused by others, such as marks from cuts, bites, burns, or punctures, or bruises or injuries, as discussed in the next section.

**Bruises and Injuries**

Assessment of bruises and injuries is particularly relevant to elder abuse because it is imperative to identify whether the cause was accidental (i.e., unintentional), inflicted by others (i.e., intentional), or self-inflicted (least commonly). Look for bruises that reflect the shape of objects, such as belts or hairbrushes, and patterns of bruises, for example, similar bruises on both upper arms that would result from being grabbed or shaken harshly. If evidence of fall-related injuries is present, consider the possibility that the person was shoved or pushed. Also consider whether the pattern of injuries matches the explanation given by the older adult or caregivers, as in the following examples: (a) bruises or fractures in people who are not ambulatory, (b) a foreword fall in people with Parkinson’s disease, who tend to fall backward. Also consider whether falls may be caused by balance and mobility problems due to overmedication by a caregiver (Gibbs, 2014).

Evidence-based information is emerging to help health care professionals identify bruises and injuries that are red flags for abusive situations. For example, a landmark study published by Mosqueda, Burnright, and Liao (2005) identified the most common places for accidental bruises in older adults as extremities (89%) and the dorsal aspect of the arms (76%). A follow-up study of bruising in older adults who were identified as victims of elder abuse resulted in the following characteristics:

- Bruises were large (e.g., at least one bruise 5 cm [2 in.] in diameter or larger)
- Bruises could be anywhere, but most often were on the face, arms, or back
Ninety percent of older adults with bruises that were inflicted by others could tell you how they got their bruises, and this included many older adults with memory problems and dementia. (Wiglesworth et al., 2009).

The figure on inside front cover can serve as an assessment guide to patterns of bruises as reported by abused elders. The authors of this study emphasize the importance of asking older adults about bruises, gently and in private.

A recent study of intentionally caused injuries in older adults presenting to emergency departments found that injuries occurring to the head, neck, or upper trunk and those involving contusions, abrasions, lacerations, or puncture were likely the result of an intentional injury. Moreover, this study found that intentionally injured older adults were much more likely to be struck by or against an object and were less likely to be hospitalized compared with those who were unintentionally injured (Yonashiro-Cho, Gassoumis, & Wilber, 2015).

Pressure Ulcers and Other Skin Indicators

Although pressure ulcers can develop even with good care, they can also be a key indicator of neglect. Important considerations with regard to pressure ulcers are as follows: (a) whether medical care is being provided and treatment has been initiated, (b) whether the treatment is effective, (c) whether caregivers understand how to manage pressure ulcers, and (d) whether caregivers implement interventions to prevent pressure ulcers when the older adult has risk factors (e.g., poor nutrition, limited mobility, exposure of skin to moisture). Skin should also be assessed for indicators of poor hygiene or infections. Body areas that are most commonly neglected are the feet, groin and genital area, and any intertriginous areas (e.g., breast or abdominal folds).

Nutrition and Hydration

Assessment of nutrition and hydration status is important in determining not only the existence of physical neglect but also the seriousness and urgency of the situation. In home and community-based settings, when nurses identify signs of malnutrition or dehydration in older adults, their next step is to determine whether the hydration or nutritional status can be improved sufficiently without removing the person from the setting. For example, simple measures such as provision of home-delivered meals or assistance with grocery shopping and
food preparation may alleviate one aspect of situations of self-neglect. Similarly, when older adults are admitted to acute care facilities with either of these diagnoses, it is important to address underlying causes during discharge planning.

### Medical Conditions

Older adults who are frail or have medical conditions are likely to develop hypothermia and hyperthermia when exposed to environmental temperatures that are even slightly too cold or too hot. In situations of neglect, caregivers may be responsible for not maintaining comfortable temperatures in living areas. For example, caregivers may not want to spend money for providing adequate heating or cooling or for repairing or replacing equipment that is not functional. In self-neglect situations, older adults may lack the cognitive capacity to sense that temperatures are not appropriate or to operate thermostats properly.

Infections can also be a sign of elder abuse, as in the following examples:

- Untreated and infected skin conditions, including wounds, leg ulcers, and pressure ulcers, due to neglect or self-neglect
- Recurrent urinary tract infections, due to sexual abuse or poorly managed incontinence
- Aspiration pneumonia, due to inappropriate feeding methods used by caregivers
- Sexually transmitted infections, due to sexual abuse

As with all aspects of assessment of older adults in abusive situations, these conditions need to be considered within the broader context.

### ASSESSMENT OF SAFETY AND FUNCTIONING

Assessment of safety in the context of elder abuse is both essential and wide ranging. It is essential because the choice of legal interventions is influenced in part by the degree of risk and the decision-making capacity of the older adult, as discussed in Chapter 8. It is wide ranging because safety issues are related not only to protection from abuse or neglect perpetrated by others, but also to self-neglect for older adults who live alone. It is also wide ranging because consequences
may be relatively harmless or they may cause irreparable damage or even death if risks are not identified and addressed.

Elder abuse situations often require an immediate determination of the degree to which the conditions are life-threatening or pose significant risks to health. In emergency departments, nursing assessments of the broader situations and risks to safety may provide essential information that influences plans for admission or discharge. In domestic elder abuse situations, it is imperative to assess the degree to which the family members or caregivers present a threat to the life of the dependent older person.

In home care settings, nurses are often the first-line health care professionals called upon to assess the situation. For example, when situations are first discovered, questions may arise about removing the person from the environment. Many times, however, the person may not want to leave, or there may be no better setting in which the person can receive care immediately. In these situations, nurses may be asked to assess the urgency and seriousness of the situation and to provide an opinion about whether legal interventions should be considered. In addition, the nurse often is the person who can either convince the older adult to accept help or convince the caregivers and social workers that the present situation is tolerable. For instance, when nurses determine that the conditions are not life-threatening, they can reassure the older adult that they are trying to improve the situation so the older adult remains as safe and independent as possible.

Safety concerns in some situations address risks not only to the older adult but also to other people and properties due to unsafe behaviors of the older adult, for example, with unsafe smoking or driving. Protection of one’s assets is a safety concern that is addressed in Chapter 15. Nurses can use Box 9.2 as a guide to assessment of safety concerns pertinent to elder abuse situations.

**Assessment of Medication Management**

Nurses routinely assess a patient’s ability to manage medical conditions, and in some situations of elder abuse this is an aspect of safety. For example, consequences can be quite serious when a person with diabetes or heart failure does not take medications correctly and lives alone. When a medication regimen is complex, it is important to determine if it can be simplified to improve adherence and support the person’s ability to remain in an independent setting. For example, in institutional settings medications might be administered four or more
### BOX 9.2 Guide to Assessment of Safety Related to Elder Abuse

**Concerns related to personal safety**
- History of physical abuse on the part of the caregiver or family member, especially when the older adult is unable to escape or otherwise be protected
- Environmental conditions in the living environment or neighborhood associated with undue risk for disease, physical harm, hypothermia,hyperthermia, or becoming a victim of crime
- Repeated episodes of getting lost or wandering in unsafe neighborhoods or in very cold weather without proper clothing
- History of frequent falls, especially if explanations do not match patterns of injuries or if the person lives alone and cannot call for help

**Concerns related to health**
- Untreated or poorly managed medical conditions
- Untreated wounds or infections
- Serious and untreated injuries
- Inability to meet basic needs (e.g., nutrition, hydration, personal hygiene, urinary and bowel elimination)
- Inappropriate use of drugs or alcohol, either self- or caregiver-induced
- Inability to recognize personal emergency situations and call for help, particularly in combination with high-risk conditions, such as frequent falls, physically abusive caregivers, and unstable medical conditions
- Suicide potential, especially in self-neglected elders who are also depressed and expressing feelings of hopelessness
- Access to toxic substances or dangerous tools or cutlery in the household without the ability to recognize the dangers

**Concerns involving risks to self and others due to unsafe behaviors of the older adult**
- Unsafe driving of vehicles
- Unsafe use of appliances (e.g., gas stoves)
- Unsafe smoking (e.g., falling asleep with lighted cigarette)
- Access to weapons without the ability to make safe and appropriate decisions about their use
different times during a 24-hour period. However, even though this might be ideal, people in home settings may not be able to follow this regimen, particularly if the older adult lives alone and requires assistance with medications.

Another assessment consideration is that elder abuse may involve caregivers withholding therapeutic medications or interfering with medical care. For example, caregivers may decide not to purchase prescriptions or provide nursing care, medical equipment, or comfort items because they do not want to spend the money, even though this care is recommended and even prescribed. If the older adult has not freely chosen to forego treatments, medications, or assistance, then this may constitute neglect. If the caregiver is likely to inherit the money that is being saved, this may represent financial exploitation as well.

**Relationship Between Functional Abilities and Risks to Safety**

In elder abuse situations, nursing assessment focuses on the relationship between functional abilities and risks to safety, as in the following examples:

- In certain medical conditions, one’s ability to follow medical regimens can have serious outcomes, for example, when a person with diabetes or heart failure does not take medications correctly.
- Bowel and bladder incontinence in people who are confined to bed or a chair can increase the risk for pressure ulcers.
- People with mobility limitations, balance problems, or serious visual impairments can be at increased risk for falls.

Similarly, nurses need to consider whether frailty creates risks for safety in elder abuse situations. For example, in self-neglect situations, an older adult who is physically healthy and fully ambulatory would not have the same degree of risk for fall-related injuries as one who weighs only 78 lbs. and ambulates unsteadily with a walker. Similarly, if the 75-year-old wife of an alcoholic man can easily escape to safety when he becomes violent, and she chooses to remain in the situation, she would not necessarily be considered a protective case. In contrast, if the woman’s decision-making capacity is questionable, and she is frail, cognitively impaired, or unable to move quickly, and is the target of violence when her husband is inebriated, the situation could be defined as elder abuse.
III Beyond Knowing About Elder Abuse

Relationship Between Assessment of Safety and Acceptance of Interventions

When risks to safety are identified in elder abuse situations, the next step is to implement interventions, as discussed in Chapter 10. A major assessment consideration in these situations is determining the extent to which the older adult is willing to accept interventions. If the older adult refuses to accept recommendations, the next step is to assess the person’s decision-making capacity, which can be an ongoing process, as illustrated in Figure 9.1.

PSYCHOSOCIAL ASSESSMENT

Decision-making capacity, which is an essential component of psychosocial assessment, is often the core issue when older adults express the desire to continue living in a situation that involves risks, as discussed in Chapter 8. This chapter discusses the following aspects of psychosocial assessment related to elder abuse: dementia, depression, the right to refuse services, the influence of drugs or alcohol, and psychological consequences of being in an abusive situation. Nursing interventions to address these issues are discussed in Chapter 10.

Dementia, Depression, and the Right to Refuse Services

As discussed in Parts I and II of this book, dementia is strongly associated with an increased risk for elder abuse in many ways. A unique aspect of dementia in relation to elder abuse is that families or caregivers may inaccurately report that a person has dementia or they may intentionally provide false information about an older adult’s abilities as a way of gaining control over assets and dominating decisions about care. Thus, it is imperative to objectively assess the effects of dementia on safety, functioning, and risk for abuse and to raise questions about observations that are not consistent with information provided by the family. Depression is also associated with elder abuse in many ways and should be assessed as a potentially treatable condition. Studies suggest depression is related to elder abuse in a bidirectional way: being a victim of abuse or neglect may be a stressor leading to depression, and being depressed may increase the older adult’s vulnerability to abuse and neglect as well as to decreased likelihood of reporting abuse (Cooper & Livingston, 2014). Nurses can use Box 9.3 as a guide to psychosocial assessment related to older adults in abusive situations.
Considerations Related to the Influence of Drugs or Alcohol

The possibility of substance abuse by the older adult should also be considered in all situations of suspected abuse or self-neglect, especially if the older adult is depressed, grieving, socially isolated, or has a history of substance abuse. Nurses also assess effects of inappropriate use or administration of psychoactive medications, either by the
BOX 9.3 Guide to Psychosocial Assessment Related to Elder Abuse

Considerations related to dementia
• Does the older adult have a diagnosis of dementia?
• Does the older adult have signs or symptoms of dementia and, if so, has any evaluation been done?
• Do family members express concerns about the older adult having dementia and, if so, are the concerns valid or are they associated with ulterior motives of the family?
• If the older adult has a diagnosis of dementia, do others use this diagnosis to impose decisions or control assets that are not consistent with the older adult’s wishes?
• If the older adult has dementia, to what extent does it increase the risk for abuse?
• If the older adult has dementia, to what extent does it affect decision making or any aspect of safety, including management of medical conditions and protection of assets?
• How do caregivers manage dementia-associated behaviors (e.g., dependency, aggression, psychiatric manifestations)?

Considerations related to depression
• Does the older adult have a diagnosis or history of depression?
• Does the older adult have signs or symptoms of depression (e.g., flat or sad affect, excessive crying, loss of appetite, unintentional weight loss)?
• If the older adult has signs or symptoms of depression, has any evaluation been done?
• Does depression, or feelings of helplessness or hopelessness, interfere with the older adult obtaining or accepting outside services?
• Is the older adult at risk for suicide, and, if so, have precautions or interventions been initiated?

Considerations related to the older adult’s right to refuse services
• If the older adult’s decision-making capacity is questionable, has a comprehensive evaluation been done by qualified professionals?
• Does the older adult acknowledge the need for support resources?
• Does the older adult express a willingness to use recommended services?
• Does the older adult understand the consequences of not accepting services?
• What are the barriers to the older adult accepting services (see Box 9.4)?
older adult or imposed by caregivers. Sometimes caregivers who abuse drugs or alcohol will give these substances to the people for whom they care, especially if the dependent person is not able or willing to refuse. Another circumstance associated with elder abuse is the use of excessive amounts of psychoactive medications solely for the caregiver’s benefit to control behaviors of the older adult. Nurses are likely to observe any of the following indicators of overmedication in an elder: confusion, slurred speech, excessive sleeping, problems with balance or mobility, or neurological adverse effects.

**Considerations Related to Emotional Consequences of Elder Abuse**

Nurses are in key positions to assess emotional consequences of elder abuse, which are often overlooked even when they are serious. It is also important to recognize that people with dementia can remember—and experience emotional consequences of—events such as abuse that have strong emotional content (Wiglesworth & Mosqueda, 2009). Nurses can use communication techniques discussed in Chapter 7 to encourage older adults to express their feelings about their situations.

**ASSESSMENT OF CAREGIVERS AND SUPPORT RESOURCES**

The term caregivers is used to describe all the people, including family members, kinship network, friends, paid caregivers, and trusted others, upon whom the older adult relies for assistance and emotional support. The term support resources describes people and services who could provide assistance and emotional support. In self-neglect situations, support resources are absent or minimal, for reasons such as lack of available services or unacceptability on the part of the older adult. In domestic elder abuse situations, major conflicts may exist among those who are involved in the care of a dependent older adult and those who are willing to provide support but are excluded for a variety of reasons. In addition, some or all of the caregivers may directly cause the abusive situation or may actively or passively contribute to it. When the people who perpetrate the abuse are also the support resources, nurses assess the potential for working with them to prevent further abuse. It is not always easy to work with abusive caregivers, but it may be even more difficult to eliminate their influence over an older adult. For example, an alcoholic son may live with his mother who has early-stage dementia and provide emotional support and minimal assistance with care but also financially exploit her and neglect her safety needs.
In addition, nursing assessment focuses on barriers to using support resources that are potential sources of assistance or support but are not currently being used. Box 9.4 delineates guidelines for nursing assessment of social supports in relation to elder abuse situations.

**BOX 9.4 Guide to Nursing Assessment of Social Supports**

Considerations related to the older adult’s perceptions of, and attitudes and knowledge about, support resources

- What does the older adult know about services that are available?
- What financial assets are available for support resources and is the older adult willing to use them?
- Does the older adult feel that family is the only acceptable source of care?
- Does the older adult mistrust service providers?
- Has the older adult had bad experiences with service providers or heard about bad experiences of others?
- Do language or cultural barriers interfere with the use of services?
- Do concerns about accessibility or transportation present barriers to obtaining health care or using community-based services?
- Does the older adult fear that the home situation will be judged as socially unacceptable?

Considerations related to support resources already involved

- What support resources are currently involved (e.g., family, friends, kinship network, local aging services, religion-based organization)?
- Are any of the caregivers also the perpetrators of abuse?
- Are any of the caregivers involved primarily for personal gain (e.g., greed, financial exploitation)?
- Do the people who are involved with caregiving have conflicts about their involvement (e.g., sense of obligation that causes excessive stress or risks to own health)?
- What are the strengths of the caregivers (e.g., availability, family loyalty and support, positive relationships)?
- What are the weaknesses of the caregivers (e.g., greed, mental health problems, lack of caregiving skills)?
- Are the caregivers willing to change the situation (e.g., accept outside resources, learn appropriate caregiving skills)?
Assessment of Family Caregivers in Relation to Needs of the Older Adult

Nurses routinely assess family caregivers, with a focus on teaching them how to manage care to the extent necessary for, and appropriate to, the situation. In some elder abuse situations, an added dimension is assessing caregivers who also may be perpetrating abuse or increasing the risk for abuse. The case example in Chapter 14 illustrates ways in which nurses work as an integral part of an interdisciplinary team to identify and address risks in caregivers to prevent elder abuse. This chapter focuses on ways in which nurses assess caregivers and family members who are actual or potential perpetrators of abuse, and Chapter 10 describes nursing interventions associated with the identified needs. An important assessment aspect is identifying strengths of the overall situation that can be built upon with interventions. This is especially important when the situation involves a caregiver who perpetrates abuse, either intentionally or unintentionally.

In clinical settings, nurses have many opportunities to interact with family caregivers when they accompany older adults to appointments or visit in institutional settings. Asking open-ended questions about the needs of the caregivers can lead to information that can be used to develop interventions. This may be particularly effective when caregivers unintentionally perpetrate abusive situations or create risks for abuse because of their lack of skills and information or their own emotional needs. Nurses can use Box 9.5 as a guide to assessment of family caregivers in relation to elder abuse situations.

**BOX 9.5 Guide to Nursing Assessment of Family Caregivers**

**Considerations related to mental health issues of caregivers**
- Is there evidence of drug or alcohol abuse in the caregiver?
- Has the caregiver been diagnosed with dementia or a mental illness (e.g., depression, schizophrenia, or anxiety disorder)?

**Considerations related to stress and coping of caregivers**
- Does the caregiver indicate that he or she is experiencing major stressors in his or her life, in addition to the stresses related to caregiving?
- Does the caregiver indicate that he or she feels undue stress from multiple demands and responsibilities?

(continued)
KEY POINTS: WHAT NURSES NEED TO KNOW AND CAN DO

- Bruises, pressure ulcers, nutrition and hydration status, and medical conditions need to be assessed in the context of the broader situation to determine whether these conditions are associated with elder abuse.
- Nurses assess safety and functioning in relation to risks for elder abuse and in relation to acceptance of intervention.
- Dementia, depression, and decision-making abilities are assessed in relation to risks and interventions for older adults in abusive situations.
- Psychosocial assessment related to elder abuse includes considerations about the emotional consequences and the possible influence of drugs and alcohol.
- Assessment of caregivers and social supports in elder abuse situations is imperative for identifying contributing conditions that can be addressed through interventions.
- It is important to observe communication between older adults and spouses, partners, friends, and family members to identify interpersonal issues that can be addressed.
- Nurses need to arrange for private assessment of the older adult and consider the need for private conversations with families or caregivers.
- It is imperative to document concerns, observations, assessment findings, and pertinent statements of the older adult and others.

REFERENCES


RESOURCES FOR ADDRESSING ELDER ABUSE

As discussed in Chapter 10, nurses have many opportunities to apply usual nursing interventions when they care for older adults who are in situations of actual or potential abuse. In addition to directly addressing these situations, nurses can often facilitate referrals for additional services and interventions that match the needs of their patients. Thus, nurses need to know not only about the range of services for elder abuse situations but also about how to access local resources. This chapter describes types of services that are commonly used to prevent and alleviate elder abuse situations in domestic settings and discusses ways in which nurses can facilitate use of these programs. Resources for addressing elder abuse in long-term care settings are discussed in Chapter 4, and Chapters 15 and 16 discuss resources for financial and sexual abuse, respectively.

GOALS AND TYPES OF SERVICES AND INTERVENTIONS

In health care settings, goals for care are limited in scope and necessarily focus on health-related needs of the older adult. In contrast, community-based services to address elder abuse focus on complex and long-term goals such as the following:

- Resolving crises and emergencies
- Ensuring victim safety
III Beyond Knowing About Elder Abuse

- Healing, empowering, and supporting victims
- Supporting the highest level of independence
- Preserving, protecting, and recovering assets
- Ensuring justice (Nureenberg, 2008)

Many types of community-based services are available to address these goals.

Types of services for elder abuse situations can be categorized according to their basic function as follows: core, emergency, support, rehabilitation, and prevention, as illustrated in Figure 11.1. Nurses in all settings can initiate or suggest referrals for services that are matched to types of abuse, as in the following examples:

- Self-neglect: home-delivered meals, community centers for meals and social activities, transportation, nonmedical home care services (e.g., companion, housekeeping, shopping, personal care)
- Neglect by caregivers: respite, care management, support and educational groups
- Physical abuse by trusted other: domestic violence hotlines
- Psychological abuse: counseling for older adult, mental health services for the older adult and perpetrator

Nurses in clinical settings have important roles in teaching about these resources because even when adult protective service workers are already involved, older adults may confide in and be amenable to suggestions from a nurse whom they trust. In many situations, nurses are the health care professionals who are best positioned to teach older adults and their families and caregivers about resources to alleviate risks for elder abuse.

AGING NETWORK SERVICES

The term Aging Network refers to the wide range of community-based services that are available through Area Agencies on Aging throughout the United States. Area Agencies on Aging were established in 1973 under the Older Americans Act to respond to the needs of Americans 60 years and over in every local community. In 2015, this Aging Network included 56 state agencies on aging, 629 area offices on aging, 246 Native American aging programs, about 29,000 service providers, and thousands of volunteers (Eldercare Locator, 2015). Virtually
all Aging Networks address elder abuse in community settings through direct services, referrals, and cooperative working arrangements. Initially, these services were available only to older adults, but they have expanded to address the needs of adults with disabilities. In addition, they have increasingly addressed needs of caregivers by funding programs that provide respite, counseling, and education. Respite services, defined as any service whose primary goal is to relieve caregivers from usual caregiving responsibilities, are provided through community-based services such as nonmedical home care agencies, adult day centers, and assisted living facilities.
In addition to the many types of services that have been available for decades, a more recent focus that is particularly relevant to nurses is the development of partnerships between Area Agencies on Aging and health care systems to administer care transition programs to assist with discharges from acute care to home care settings. These programs have been funded by the Affordable Care Act to address concerns about unnecessary hospitalizations of older adults. Another focus related to health care for older adults with chronic conditions is the provision of evidence-based health promotion programs endorsed by the Centers for Disease Control and Prevention and the Administration on Aging. Nurses can encourage older adults or their caregivers to explore these types of resources, which are described in Box 11.1. In many situations, services such as these are effective in reducing risk for abuse and alleviating contributing conditions when abuse is occurring or has occurred.

BOX 11.1 Services Provided by Aging Networks

<table>
<thead>
<tr>
<th>Services most commonly available</th>
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<tbody>
<tr>
<td>Meals, in congregate settings or delivered to homes</td>
</tr>
<tr>
<td>Chore services: housekeeping, shopping</td>
</tr>
<tr>
<td>Assistance with personal care</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Socialization in community centers</td>
</tr>
<tr>
<td>Adult day centers</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Services to address needs of caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Caregiver education</td>
</tr>
<tr>
<td>Counseling</td>
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<td>Support groups</td>
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<table>
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<tr>
<th>Services to divert people from prematurely being admitted to a long-term care setting</th>
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</thead>
<tbody>
<tr>
<td>Assessment</td>
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<tr>
<td>Counseling about options</td>
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(continued)
Services delineated in Box 11.1 are generally available according to geographic location with additional criteria applying in some cases. For example, some programs are based on assessment of need, such as being homebound to qualify for home-delivered meals. Services are sometimes provided without charge; in other cases, fees may be based on income or other criteria. The Eldercare Locator is an essential national resource for information about all services within the Aging Network. Online information for types of services by geographic location is available at www.eldercare.gov. During weekday business hours, information specialists are available at 1-800-677-1116 to discuss programs and services in English or Spanish or with a telecommunication device for people who are deaf. In addition, online chats or language interpretation services are available for 150 languages during these hours. In 2014, 27% of the calls were related to elder abuse and 29% addressed caregiver issues (Administration for Community Living, 2014).
CASE 11.1 Elder Network Services for Mrs. Kryzynski

Mrs. Kryzynski, who is 85 years old and lives in her own home, was admitted to the hospital 2 days ago with fractured ribs, neck pain, and multiple contusions over her chest and face. While driving to church, she had been rear-ended after stopping suddenly—and unnecessarily—at a yellow caution light. The emergency department physician admitted her because, in addition to her injuries, her breathing was labored and her lungs were congested. Chronic conditions include diabetes, hypertension, rheumatoid arthritis, macular degeneration, and chronic obstructive pulmonary disease.

During her hospitalization, Mrs. Kryzynski confided that she is reluctant to drive again because she has had several “close calls” even before the accident 2 days ago. She states, “My eyesight has been getting a little worse every few months but if I can’t drive I’m afraid I’ll become a recluse like my friend who died a couple months ago.” Now her car is damaged again and she indicates that she will give up driving rather than get her car repaired. She also tells you that she needs to drive to the grocery store at least every week and she definitely does not want to give up her attendance at church. When you review the discharge orders with Mrs. Kryzynski, you add information about calling the Eldercare Locator to find resources for transportation. You also suggest that she may want to consider attending the local senior center for lunches and social activities, so she does not become socially isolated.

RESOURCES FOR SPECIFIC GROUPS

In addition to services commonly included in the Aging Network, faith-based and culturally specific resources may be available in some communities. Also, the Veterans Administration is often overlooked as a resource for older adults and caregivers. Older adults who identify with a particular group or religious denomination may find that these resources are more acceptable than other community-based organizations. Nurses can also consider suggesting resources such as Alcoholics Anonymous or Al-Anon in situations involving substance abuse by either the older adult or a family caregiver. Local offices on aging can usually provide information about programs such as the types described in this section.
Faith community nursing (also called parish nursing), which has been recognized by the American Nurses Association since 1998, is a specialized practice of professional nursing that focuses on care of the spirit as well as on the prevention or minimization of illness within the context of a faith community (American Nurses Association, 2012). Faith community nurses spend 50% to 100% of their time providing services to older adults, such as referrals, personal counseling, spiritual support, and health advocacy (King & Pappas-Rogich, 2011). Many Jewish organizations provide a wide range of community-based services for older adults, including programs specifically addressing elder abuse. These resources may be particularly effective for addressing issues related to caregivers or family dynamics and situations in which the older adult would benefit from advocacy.

Culturally specific resources are increasingly available, as discussed in Chapter 5. Since 1978, the Older Americans Act has funded Aging Network services for Indian tribal organizations, with a current focus of these programs on elder abuse. Culturally specific programs are especially pertinent for older adults who are immigrants and for those who do not speak English. In recent years, there has been increasing development of services for Korean or Chinese older adults, including community centers, home care services, adult day centers, and options for long-term care.

The Veterans Administration provides many home and community-based services for veterans of any age and their caregivers. Services that are relevant to prevention of elder abuse include home-based primary care, homemaker and home health aide services, respite care, care management, rehabilitation therapies, and adult day health care. Older adults who are veterans are often unaware of home and community-based services, particularly if they receive their primary care from sources not connected with the Veterans Administration. Nurses can encourage veterans and their family caregivers to explore resources for home and community-based services at www.caregiver.va.gov.

**COMPREHENSIVE GERIATRIC ASSESSMENT PROGRAMS**

Comprehensive geriatric assessment programs are a resource within the health care system that can be used for addressing many situations involving actual or potential abuse, particularly those that involve questions about the health, functioning, and decision-making capacity of the older adult or plans for long-term care. Comprehensive geriatric assessment programs provide multidimensional and multidisciplinary
CASE 11.2 Mr. Hobbs, World War II Veteran

Mr. Hobbs was hospitalized several years ago with a blood clot in his leg. Upon returning home, Mr. Hobbs had limited mobility and his wife had a difficult time transferring him between his bed and his lift chair. The Veterans Administration hospital provided a Hoyer lift, which enabled Mrs. Hobbs to continue caring for her husband in their home. Two-and-a-half years ago, Mr. Hobbs was admitted into the home-based primary care program for monthly blood draws. Over time, home-based primary care provided additional medical equipment, including a hospital bed, electric scooter, and an exercise peddler. Mrs. Hobbs was a devoted caregiver and did not want to use the services of the homemaker and home health aide or respite programs. Mrs. Hobbs continued to care for her husband all alone, even sacrificing her health at times. During monthly visits, the home-based primary care nurse and social worker would reinforce the programs available and encourage Mrs. Hobbs to use them to decrease some of the work she did on a daily basis. Eventually, Mr. and Mrs. Hobbs began to accept additional services. Now a home health aide assists Mr. Hobbs with bathing, grooming, dressing, and transfers. Mrs. Hobbs agreed to use the in-home respite program, and now says, “I didn’t realize that just to get away really does help.” Mrs. Hobbs describes a recent time when she was recovering from an illness and used the in-home respite program. While she was resting, the home health aide cleaned her home, which is still something she never expects but truly appreciates.

Adapted from Donetta’s Story, posted at www.caregiver.va.gov

assessments of all aspects of health and functioning and recommend interventions to help the older adult function at his or her highest level. Assessments are performed and discussed by team members, which typically include geriatricians, gerontological nurses, social workers, geriatric mental health professionals, and rehabilitation therapists. Team members assess the older adult and seek input from family members and caregivers. The team recommends interventions to address issues and works with older adults and caregivers to develop a plan for the appropriate level of care in home, community-based, or long-term care settings.
Outpatient geriatric assessment programs are widely available at large medical centers, teaching hospitals, and university-based gerontology centers. Inpatient geriatric assessment programs are also available either as a specialized geriatric unit or as a component of geriatric behavior and mental health services. Geriatric assessment programs generally accept referrals from any source and serve as consultants for primary care providers on an intermittent or short-term basis. Nurses in all settings can teach older adults and family caregivers about these resources whenever questions arise about decision-making capacity or the most appropriate level of care for an older adult.

CASE 11.3 Miryam Perlman, Geriatric Assessment Program

At Miryam Perlman’s 80th birthday party, her family and friends toasted her long-standing characteristics of being “feisty and independent to the end.” During the 8 months since her party, however, more than a few people who have seen her recently have noticed that her fastidious way of being well groomed and neatly dressed has changed. Her clothes are soiled and hang loosely. Several months ago, she stopped attending the Shabbat services at the Beth Israel Temple, which she had attended for many decades. After members of the congregation expressed their concerns to Rabbi Cohen, he visited Miryam and was troubled by what he observed. Miryam’s house was in disarray, with dirty dishes piled in the kitchen, and little evidence of proper food preparation. He guessed that she had not bathed in quite a while and her hair was oily and uncombed. When he talked about recent events at the Temple, she conversed as if she knew about them, but the details she described were related to events that happened 20 years ago. When he asked about visits from her son or daughter, who both live in other states, she said, “Oh, they were here just a few days ago, and they are fine.” He asked if it would be OK if he called her daughter, and, although she saw no need for the contact, Miryam agreed.

When Rabbi Cohen talked with Miryam’s daughter, she told him that neither she nor her brother had seen their mother since Miryam’s birthday party 8 months ago. They have both talked with their mother on the phone, and expressed their concerns that she seems a “little fuzzy” but she always insists that “everything is just fine here.”
SERVICES TO ADDRESS NEEDS OF CAREGIVERS

Nurses commonly have frequent contact with family caregivers and are in key positions to discuss community-based resources. This is particularly important for families and caregivers of people with dementia because of the increased risk for elder abuse in these situations. In addition to the Aging Network services that address needs of caregivers, many resources are available for education, support, and actual caregiving. Local Alzheimer’s Associations are a primary source of information about services to address caregiver needs, and the information is applicable to all caregiving situations regardless of medical diagnoses. Box 11.2 lists governmental and nonprofit resources to support caregivers.
RESOURCES SPECIFICALLY FOR ELDER ABUSE

Resources described in this section are used to resolve actual elder abuse situations and generally are accessed through public agencies, such as adult protective services. Although nurses are usually not involved with referrals for these programs, nurses are often in positions of teaching older adults and families about the scope of community-based resources for addressing abuse.

Adult Protective Service Agencies

In addition to investigating alleged elder abuse cases (discussed in Chapter 6), adult protective service agencies provide interventions when the older adult is willing to accept services. If case workers assess that services are necessary but the older adult refuses to accept them, the adult protective services agency may arrange for an evaluation of the person’s decision-making capacity. If a court deems that the person is incompetent, legal actions are initiated, but in all other situations the person’s autonomy will be respected.

Care management and care coordination are essential components of adult protective service agencies. Agencies are staffed by several levels and types of workers, including nurses, social workers, and non-medical home care assistance. In addition, they are an integral part of the Aging Network and commonly have contractual arrangements with other professionals and agencies, such as psychiatric and mental health providers.
health services, legal advisors, and animal protection agencies. Public health and home care agencies often provide nursing consultations, assessment, or direct care interventions for adult protective agencies that do not employ nurses. Case consultation is a service offered by adult protective service agencies that is especially relevant to nurses who are seeking guidance about a questionable situation that they encounter in their clinical setting.

**Multidisciplinary Teams**

Since the early 2000s, multidisciplinary teams (also called M-teams, interdisciplinary teams, or I-teams) have been considered the “gold standard” for addressing elder abuse. Teams generally include professionals who offer the perspectives of law, nursing, medicine, psychiatry, social work, and rehabilitation therapy, with additional disciplines included when required. When legal interventions are being considered, the multidisciplinary team conducts or arranges for a comprehensive assessment, including all aspects of the person’s functioning and decision-making capacity, the involvement of the family and significant others in meeting basic needs, and the ability of the older person to participate in developing a safe and realistic plan of action.

Roles and activities of multidisciplinary teams vary, but an overarching goal is to provide a holistic perspective, which is essential for thoroughly assessing the problem and determining appropriate solutions. In addition, team members collaborate in handling complex and difficult cases and they can establish effective approaches to elder abuse prevention and treatment (Anetzberger, 2011). Multidisciplinary teams differ in their ability or willingness to provide direct interventions; however, the case review from knowledgeable professionals is a valuable resource for the service providers who are responsible for interventions.

Nurses participate in these teams and provide initial and ongoing assessment as well as direct care or consultation related to health-related issues, such as management of medical conditions, treatment of pressure ulcers, and education about safety risks. Chapter 13 illustrates the way in which a multidisciplinary team provides consultation to a nurse to address self-neglect in a rural setting.

**Specialized Elder Abuse Teams**

In recent years, specialized teams have evolved to address particular elder abuse situations, such as financial abuse (discussed in Chapter 15)
and hoarding, including animal hoarding. Elder abuse forensic centers provide multidisciplinary case reviews of situations that involve possible violations of laws (e.g., financial abuse, physical abuse, sexual abuse). Box 11.3 describes examples of specialized elder abuse teams and services.

**BOX 11.3 Examples of Specialized Elder Abuse Teams and Services**

**Elder Abuse Forensic Center**
- Multiagency team case review and development of action plan
- Medical and neuropsychological evaluations
- Forensic evaluation and documentation
- Victim assistance and support services
- Consultation, education, and training

**Texas Elder Abuse and Mistreatment (TEAM)**
- Medical evaluations in homes, hospital, or outpatient settings
- Teleconsulting: provides onsite medical consultation to adult protective service workers
- Financial abuse specialist team (FAST): includes medical professionals and law enforcement members who review cases of exploitation and fraud committed against the elderly
- Elder abuse fatality review team: reviews suspicious elder deaths
- Resource rooms: enable adult protective services workers to find basic necessities and emergency supplies, such as dietary supplements, adult diapers, and assistive devices

**Elder Abuse Institute of Maine**
- Martha’s Cottage: provides transitional home for elder abuse victims, who can stay for up to 24 months

**Fatality (Death) Review Teams**
- Multidisciplinary teams: explore unexplained deaths of older adults, distinguish “natural” deaths from those associated with crimes, and shed light on events leading up to deaths
- Assist in prosecution of alleged perpetrator
Emergency Shelter and Transitional Housing Programs

Emergency shelter programs provide a safe place where abused older adults can receive immediate and short-term health, housing, legal, and counseling services. These programs are usually located in long-term care settings, such as nursing homes or assisted living facilities. The Weinberg Center for Elder Abuse Prevention, which is part of the New York City Hebrew Home, established the first emergency shelter program for older adults in 2005. Since then, shelters specifically for older adults have been developed in many states, including Arizona, Minnesota, Nebraska, Ohio, and Vermont. In 2009, the Elder Abuse Institute of Maine opened the first transitional home for victims of elder abuse, called Martha’s Cottage, with initial and ongoing funding from the U.S. Department of Justice. Women age 60 and older who are seeking safety from a violent household can stay in the house for up to 24 months.

Nurses in emergency departments and outpatient settings can initiate referrals or teach older adults about these resources. In hospital settings, information about emergency shelters can be included in discharge instructions for older adults who are choosing to return to situations of domestic abuse. It is important to maintain strict confidentiality about this information and assure that perpetrators do not become aware of it. Information about local emergency shelters is available at the National Domestic Violence Hotline (1-800-799-7223 [SAFE]) or through the adult protective service agencies listed in Appendix B.

CASE 11.4  Emergency Shelter for Mrs. Ackerman

During a follow-up appointment for hypertension, Nurse Practitioner Laura notes that Mrs. Ackerman seems unusually anxious and has black and blue bruises across her forehead, around her left eye, and on both upper arms. Mrs. Ackerman is 73 years old and lives with her husband, who is 67 years old. When Nurse Practitioner Laura asks her patient about the bruises, Mrs. Ackerman initially says she walked into the door when she got up to go to the bathroom a couple nights ago. Mrs. Ackerman avoids eye contact and changes the subject after answering briefly. When Nurse Practitioner Laura asks her patient if she feels safe at home, Mrs. Ackerman begins to cry and admits that her husband grabbed her by her arms and threw her

(continued)
IN Voluntary Measures

Although the first principle of adult protective services is to protect the person’s autonomy, some situations involve the use of involuntary measures, such as guardianship or civil commitment. State laws define the processes for these measures, which are implemented under court supervision. Nurses in most health care settings are not directly involved with involuntary interventions, but it is important to be aware of these interventions when caring for older adults in abusive or potentially abusive situations. When nurses address any situations involving consideration of involuntary measures, they can call adult protective services. They also have roles in explaining these measures to families.

Guardianship (also called conservatorship) is the legal process that appoints a surrogate decision maker for people who have been determined to be incompetent (i.e., unable to make decisions for themselves). Court proceedings can be initiated by any concerned individual, including families, health care providers, attorneys, or adult protective service agencies. The person is entitled to legal representation and an extensive evaluation is required. If the judge determines that the person is incompetent, a partial or full guardianship is appointed. Although guardianships can be revoked or reversed through additional court action, it generally remains in place until the incompetent person dies. Usually, guardianship is initiated only as a last resort when no other legal intervention is appropriate because it is a drastic measure that takes away rights and entails court proceedings and ongoing court monitoring.

Civil commitment, also known as an involuntary psychiatric hospitalization, is used when older adults are too impaired to protect
themselves or when they pose a threat to themselves or others. Geropsychiatric programs and geriatric behavioral health units in hospitals accept involuntary admissions for evaluation, management, and discharge planning.

KEY POINTS: WHAT NURSES NEED TO KNOW AND CAN DO

- Many community-based resources are available for preventing and addressing elder abuse.
- Community-based services for abused older adults focus on complex and long-term goals, including supporting the older adult’s highest level of independence.
- Community-based services address the needs of caregivers as well as of older adults.
- Recognize that specialized programs and services for specific groups may be acceptable even when other programs are not.
- It is imperative to build on a trusting nurse–patient relationship to address barriers to the use of services.
- Nurses have important roles in teaching older adults and their caregivers about accessing needed services.

REFERENCES


