Elder Abuse

Human Behavior in the Social Environment
California State University, Los Angeles, School of Social Work

Objectives/Competencies

1. To view the aging process from a normative perspective as opposed to a disease state.
2. To increase knowledge of normal biological changes of the aging process.
3. To identify potential risks of to the aging process.
4. To identify the signs of abuse and/or neglect.
5. To increase knowledge of the major biological and social aging theories.
6. To apply a gerontological perspective to social and developmental theories.

Elder Abuse and Neglect

Every state in the United States has incorporated laws to protect dependent adults and the elderly. Social workers are mandated reporters of elder abuse and neglect. In California, Adult Protective Services (APS) is the agency that provides protective services for dependent adults and seniors, 65 years and older. APS is administered under state guidelines, but each county is “responsible for the intake process, investigation/assessment, and case work functions” (Goodrich, 1997).

“The California Department of Adult Protective Services divides elder abuse into two categories: 1) abuse inflicted by others and 2) self-inflicted abuse. Abuse inflicted by others includes physical abuse, sexual abuse, neglect, abandonment, fiduciary abuse, mental suffering, and isolation. Self-inflicted abuse includes physical abuse (self-neglect, alcohol and drug abuse), fiduciary abuse (financial mismanagement to the extent that funds have been diminished or depleted), and suicide (attempted or threatened suicide)” (Northern California Council for the Community, 1997).

In 1998, there were 13,182 reports of alleged abuse and neglect in Los Angeles, an average of 1,173 reports per month. Reports of self-neglect are the most common reports to Adult Protective Services (APS). It is also estimated that only 7% of all elder abuse and neglect incidents are reported (Kopfleisch, & Finucane, 2001).

Currently there is no definitive information on the incidence of elder abuse and neglect within ethnic and minority populations. This is important given the diversity of the population in California. Conflicting data indicates a need for additional research in this area (Tatara, 1999).

Biological Aging

Aging is a process. The aging process begins at birth and is the normal continuum of the life course development; it is not an indicator of disease. It is important to recognize what are normal or true age changes, what are the results of disease, abuse, disuse, and misuse, and what can be prevented. Normative aging, for the mature adult, includes biological changes such as declines in the functioning of hearing, vision, skin-elasticity, regulation of body temperature, hair color, and hair loss. Normative aging is also reflected in a slowing of biological systems. The rate of decline is related to the individual’s genetic predisposition, environment, and lifestyle. Genetic changes may be an option for the future, but a lifestyle including moderate exercise and a healthy diet can delay the decline of functioning. The
perception that disease is associated with aging is inaccurate. Disease is more often related to extended exposure to elements that can cause disease. For example, lung cancer is not a consequence of aging but a disease that may not develop until later life due to a lifetime of exposure to pollution, smoke, and/or asbestos. Heart disease is the leading cause of death for the older adult but may be prevented by exercise and a healthy diet and is not due to normative aging.

**Physiological Systems Aging Changes**

Changes in the **neurological system** include a slowing of response times; it takes longer for neurotransmitters to send and receive messages. The decline in response time does not indicate cognitive decline. Slight losses in short-term memory and complex problem solving ability are often considered normative, but cognitive decline is not a part of normal aging and is an indication of disease. There are changes in the circadian rhythm as we age. Older adults experience less time in the restorative deeper sleep and generally sleep 6 hours a night and fall into a pattern of napping during the day. Common neurological diseases include: stroke, Alzheimer’s Disease, Parkinson’s Disease, and dementias. These diseases are not exclusive to the older adult.

**Cardiovascular system** changes include the accumulation of fatty deposits in the heart and a decrease in the elasticity of the blood vessels. Although this may decrease the functioning of the heart thus decrease the oxygen supply to all vital organs, which may result in increased fatigue, it does not constitute a disease state. Exercise and a healthy diet can improve the cardiovascular system. Common disease states include Congestive Heart Failure (CHF), Coronary Heart Disease, and Hypertension.

A common effect of aging in the **musculoskeletal system** is the compressing of the spine resulting in becoming shorter. The musculoskeletal system is influenced by the endocrine system. The loss of hormones (estrogen in women and testosterone in men) can cause a loss in muscle mass and bone density. Once again exercise is key in maintaining muscle mass and strong bones. Senile osteoporosis is the deterioration of bone density that affects both men and women in the most advanced ages, causing bones to become brittle. Common diseases include osteoporosis (primarily in women), osteoarthritis, scoliosis, kyphosis (Dowager’s hump), and tooth loss due to periodontal disease. The lack of preventative dental care increases risk of tooth loss, which can affect the digestion of food.

**Gastrointestinal system** changes include a narrowing or loss of elasticity of the esophagus, which may result in difficulty in swallowing, the feeling of fullness, and the feeling that food is stuck in the throat. The small and large intestines tend to decrease in size due to general water loss normal to aging. This may also contribute to constipation or bowel obstructions. Weight loss is a serious problem for the older adult due to digestive problems such as tooth loss, decline in ability to taste and smell, difficulty with swallowing, and constipation.

Normative aging in the **respiratory system** is hard to define, as it is still unclear to what extent environmental factors are involved. Muscles that coordinate lung function begin to lose strength and elasticity, which impairs the ability to cough deeply and to expel toxins; pneumonia and bronchial infection may result. Aging changes also include a decrease in cilia and the ability to breathe efficiently. Slower more shallow breathing can result in insufficient oxygen intake to all organs in the body, decreasing the efficiency of total body functioning. Lung functioning may be improved with exercises to strengthen the diaphragm.

The **urinary tract system** is crucial in maintaining mineral balance and filtering wastes from the body. As the body ages it can lose sensitivity to the pain normally associated with inflammation and infections of the bladder and/or kidneys. As the body ages, the bladder may lose elasticity causing an inability to fully empty the bladder, increasing risk of infection. Prostate enlargement in men can also
interfere with the ability to empty the bladder. Urinary tract infections (UTIs) may go unnoticed by the individual and left untreated can eventually result in symptoms of dementia. Incontinence is frequently a problem for the older adult but is often treatable with medication. Incontinence is one of the reasons that many older adults limit their social activities (isolation) and are at risk of dehydration.

The endocrine system is responsible for a number of system functions that are dependent on hormones. The decrease of estrogen production in women marks the loss of reproductive abilities and places women at higher risk for osteoporosis, heart disease, and urogenital atrophy (thinning of the vaginal walls). Exercise and calcium supplements can help delay osteoporosis until very old age when the onset of senile osteoporosis may set in. Vaginal lubricants can help remedy the dryness and pain that can occur during intercourse. The decrease in testosterone in men can diminish their sex drive, increase the time it takes for them to get an erection, and the completion of orgasms becomes less frequent. Another vital function of the endocrine system is the production of insulin by the pancreas. Insulin is vital to the metabolism of glucose into energy. Adult onset diabetes is the chronic inability of the pancreas to produce enough insulin. Symptoms include increased appetite, increased thirst, frequent urination, poor circulation, slow healing of wounds, and fatigue. Untreated diabetes can result in blindness, kidney failure, heart and blood vessel damage, and amputations.

The sensory system includes vision, hearing, touch/physical sensations, taste, and smell. The sensory system changes occur over time gradually, thereby allowing most individuals time to compensate for the declines and transition more smoothly. Age changes in vision can occur in the late 30’s when the orbital muscles begin to relax resulting in presbyopia (failure to focus on near objects). With aging, the pupil of the eye becomes smaller and less responsive to changes in light. Seniors are more sensitive to light and glare and often have difficulty driving at night due to the glare of the headlights. Frequently there diminished abilities to distinguish differences in color, which results in loss of depth perception and decreases in peripheral vision.

There are three diseases that affect the elderly but are not normal aging changes: cataracts, glaucoma, and macular degeneration. A cataract is a thin film that covers the lens of the eye clouding normal vision. It is caused by a lack of antioxidants found in vitamin A, vitamin C, and vitamin E. Glaucome is a condition of abnormal pressure in the eye, which results in the detachment of the retina. Untreated it can result in tunnel vision or blindness. Macular degeneration is a slow degeneration of the central vision. Individuals with this disease can see peripherally but are unable to see directly in front of them. African Americans have a higher frequency of cataracts and have the highest rate of blindness due to glaucoma in the United States.

Hearing loss can be caused by continued exposure to an environment of loud noises or frequent exposure to loud music or noise. Changes associated with aging are connected with the inability to distinguish between sounds as opposed to not being able to hear them. Each ear may not be affected at the same rate of decline. The differing impulses to the brain from each of the ears can cause disorientation and problems with equilibrium. The use of hearing aids often exacerbates the inability to distinguish between sounds, since it is used to amplify sound. Speaking in lower tones to the older adult may help the older adult understand what was said more clearly.

Due to the decline of the responsiveness in the neurotransmitters, older adults do not experience physical sensations the same as when they were younger. A higher threshold or insensitivity to pain places the senior at greater risk for burns, infections, and decubitus (ulcers, pressure sores). Seniors may not seek needed medical attention due to decreased intensity of symptoms, considering it more of a discomfort or something not to be bothered with. The sensitivity to temperature is also affected during the
aging process. The body’s ability to self regulate temperature diminishes which can result in the slowing of cellular chemical reactions and/or cellular damage.

The ability to **taste and smell** decreases during the aging process, which can diminish one’s appetite and put the elder at risk of malnutrition and eating spoiled food. The inability to smell acutely also places the elder at risk for gas leaks and fire.

* See Handout (Table One) of Physiological Systems Aging Changes

The role of a social worker is not to diagnose disease but to evaluate the older adult’s ability to live independently and assist in creating and coordinating interventions that will help the client to maintain his/her independence and quality of life for as long as safely possible. When the older adult can no longer live safely or maintain his/her quality of life at home, then the role of the social worker is to assist them in transitioning into a safe environment.

Additional knowledge is essential in differentiating biological changes in the aging body from possible indicators of abuse/ neglect.

*See Handout (Table Two) of Changes Due to Normal Aging and Potential for Abuse Neglect*
# Table 1. Physiological Changes and Aging

<table>
<thead>
<tr>
<th>Biological Systems</th>
<th>Normative Aging</th>
<th>Common Disease States</th>
</tr>
</thead>
</table>
| Neurological         | Slight decline in cognitive functioning abilities, short-term memory and complex problem solving skills Decline in response time of neurotransmitters Changes in circadian rhythm | Stroke  
Alzheimer’s Disease  
Parkinson’s Disease  
Dementias (infection, dehydration, malnutrition) |
| Cardiovascular       | Normal plaque build-up in arteries may cause reduced oxygen flow to all other organs resulting in fatigue. Exercise and a healthy diet can improve cardiovascular functioning. | Coronary Artery Disease  
Congestive Heart Failure  
Hypertension |
| Musculoskeletal      | Decline in height Decrease in muscle mass                                        | Osteo-arthritis  
Osteoporosis  
Tooth Loss |
| Gastrointestinal     | Gastric Reflux due to narrowing of esophagus  
Loss of appetite due to decline in taste and smell  
Constipation due to water loss in intestines | Malnutrition/Dehydration  
Anemia  
Gastric Ulcers  
Stomach Cancer  
Colon Cancer |
| Respiratory          | Uneven lung ventilation due to narrowing of bronchioles, increase of viscous mucus, and weakening of diaphragm. | Chronic Obstructive Pulmonary Disease (COPD)  
Lung Cancer |
| Urinary              | Bladder decreases in size and elasticity  
Decrease in sensitivity of bladder and urethra | Incontinence  
Urinary Tract Infection (UTI)  
Nocturia |
| Endocrine/Reproductive | Decrease in muscle mass  
Menopause/estrogen decline in women  
Testosterone decline in men | Diabetes  
Prostate Cancer |
| Sensory              | Decline in: skin elasticity, hearing, vision, taste, smell, and touch  
Hair loss and graying | Skin Cancer  
Glaucoma  
Cataracts  
Macular Degeneration |
Table 2  Changes Due to Normal Aging and Potential for Abuse/Neglect

<table>
<thead>
<tr>
<th>AGING PROCESS</th>
<th>NORMAL AGING OUTCOMES</th>
<th>IMPLICATIONS FOR POTENTIAL ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of skin thickness</td>
<td>Skin becomes paper thin</td>
<td>Immobilization and neglect may cause bedsores, skin infection, bruises, skin laceration (potential for physical abuse)</td>
</tr>
<tr>
<td>Atrophy of sweat glands and decreased blood flow</td>
<td>Decreased sweating, loss of skin water, dry skin</td>
<td></td>
</tr>
<tr>
<td>Increased wrinkles and laxity of skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased lung tissue elasticity</td>
<td>Reduced overall efficiency of gases exchanged</td>
<td>Immobilization and neglect may cause lung infection Decreased stamina may result in dependence and isolation</td>
</tr>
<tr>
<td>Decreased respiratory muscle strength</td>
<td>Reduced ability to handle secretions and foreign particles</td>
<td></td>
</tr>
<tr>
<td>Heart changes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart valves thicken; increased fatty deposits in artery wall; increased hardening, stiffening of blood vessels; Decreased sensitivity to change in blood pressure</td>
<td>Decreased blood flow</td>
<td>Potential for falls/injuries, physical and psychological abuse</td>
</tr>
<tr>
<td>Decreased blood flow</td>
<td>Decreased responsiveness to stress, confusion and disorientation</td>
<td></td>
</tr>
<tr>
<td>Decreased peristalsis</td>
<td>Prone to loss of balance</td>
<td></td>
</tr>
<tr>
<td>Gastric and intestinal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atrophy and decreased number of taste buds</td>
<td>Altered ability to taste sweet, sour, salt and bitter</td>
<td>Mal/under nutrition</td>
</tr>
<tr>
<td>Decreased gastric secretion</td>
<td>Possible delay in vitamin and drug absorption</td>
<td>Fecal impaction (potential physical abuse)</td>
</tr>
<tr>
<td>Decreased gastric muscle tone</td>
<td>Altered motility</td>
<td>Change in how medications are absorbed, resulting in possible over-medicating, resulting in falls, confusion, etc.</td>
</tr>
<tr>
<td>Decreased peristalsis</td>
<td>Decreased hunger sensations and emptying time</td>
<td></td>
</tr>
<tr>
<td>Bladder:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased bladder muscle tone and bladder capacity</td>
<td>Increased residual urine</td>
<td>Incontinence along with immobilization and neglect may cause skin breakdown and/or bedsores</td>
</tr>
<tr>
<td>Sensation of urge to urinate may not occur until bladder is full</td>
<td></td>
<td>Potential for falls and injuries when having to get up more at night</td>
</tr>
<tr>
<td>Increased risk of infection, stress incontinence</td>
<td>Urination at night may increase</td>
<td>Incontinence is the single most predictive factor for abuse</td>
</tr>
<tr>
<td>Enlarged prostate gland in male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscles, joint and bone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased muscle mass</td>
<td>Decreased muscle strength and increased muscle clamping; Greater risk of fractures; limitation of movement; Potential for pain</td>
<td>Immobilization and neglect may cause contracture deformities (potential for physical and psychological abuse)</td>
</tr>
<tr>
<td>Deterioration of joint cartilage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased bone mass</td>
<td></td>
<td>Increased potential for falls</td>
</tr>
<tr>
<td>Decreased processing speed and vibration sense</td>
<td></td>
<td>More likely to fracture under less impact than a bone of a younger person</td>
</tr>
<tr>
<td>Decreased nerve fibers</td>
<td></td>
<td>Less strength resulting in increased isolation and dependence on caregiver.</td>
</tr>
<tr>
<td>AGING PROCESS CHANGES</td>
<td>NORMAL AGING OUTCOMES</td>
<td>IMPLICATIONS FOR POTENTIAL ABUSE</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Sensory:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in sleep-wake cycle</td>
<td>Increased or decreased time spent sleeping</td>
<td>Neglect and social isolation (potential for financial abuse)</td>
</tr>
<tr>
<td>Slower stimulus identification and registration Decreased visual acuity</td>
<td>Increased nighttime awakenings</td>
<td>Falls, fractures and injuries (potential for physical and psychological abuse)</td>
</tr>
<tr>
<td>Slower light and dark adaptation Difficulty in adapting to lighting changes</td>
<td>Delayed reaction time</td>
<td></td>
</tr>
<tr>
<td>Distorted depth perception</td>
<td>Prone to falls</td>
<td></td>
</tr>
<tr>
<td>Impaired color vision</td>
<td>Increased possibility of disorientation</td>
<td></td>
</tr>
<tr>
<td>Changes in lens</td>
<td>Glare may pose an environmental hazard; Incorrect assessment of height of curbs and steps</td>
<td></td>
</tr>
<tr>
<td>Diminished tear secretion</td>
<td>Presbyopia (diminished ability to focus on near objects)</td>
<td></td>
</tr>
<tr>
<td>Decreased tone discrimination</td>
<td>Presbycusis (high frequency sounds lost)</td>
<td></td>
</tr>
<tr>
<td>Decreased sensitivity to odors</td>
<td>Less able to differentiate lower color tones e.g. blues, greens</td>
<td></td>
</tr>
<tr>
<td>Reduced tactile sensation</td>
<td>Dullness and dryness of the eyes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decreased ability to sense pressure, pain, temperature</td>
<td></td>
</tr>
<tr>
<td>Immune system:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decline in secretion of hormones; Impaired temperature regulation; Impaired immune reactivity; Decreased basal metabolic rate</td>
<td>Decreased resistance to certain stresses (burns, surgery, etc.)</td>
<td>Bedsores; Infections; Fractures; Isolation; Dependence</td>
</tr>
<tr>
<td></td>
<td>Increased susceptibility and incidence of infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased incidence of obesity</td>
<td></td>
</tr>
<tr>
<td>Mental and cognitive:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some cognitive and mental functions decline; Some cognitive skills including judgment, creativity, common sense, and breadth of knowledge and experience, are maintained or improved. Some cognitive skills, including abstraction, calculation, word frequency, verbal comprehension, and inductive reasoning, show slight or gradual decline.</td>
<td>Short-term memory declines but long-term recall is usually maintained Difficulty understanding abstract content Learning abilities change -- older adults are more cautious in their responses; are capable of learning new things but their speed of processing information is slower.</td>
<td>Potential for financial abuse and exploitation Increased risk for self-neglect</td>
</tr>
</tbody>
</table>

Source: California State University, Los Angeles, School of Social (2003). Adult Protective Services Worker Training for The California State University Department of Social Services.
Risks Associated with Aging

The importance of understanding normal aging is to identify the risks that face the elderly. An older adult can remain fit and healthy well into his/her nineties; but as the functioning abilities and mobility of the elder declines the risks of abuse and neglect increases. As physical or mental capacities diminish the elder becomes increasingly dependent on others for assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). The ADLs consist of the ability to complete independently the tasks of: eating, transferring, toileting, bathing, and dressing/grooming. The IADLs consist of the ability to complete independently the tasks of: meal preparation, transportation, housekeeping, shopping, money management, medication management, and the use of the telephone. The elder may not have enough social supports to assist in the caregiving needs, which may lead to frustration for both the elder and the primary caregiver. Caregiver stress and burnout increases the risk of elder abuse.

Another factor that can cause a decline in mobility and functioning is injury due to falls. Falls are the leading cause for injury and injury related deaths for persons 65 years and older in the United States. In 1997, falls accounted for 72% of all injury hospitalizations for seniors in California and falls accounted for 80,000 hospitalizations of California’s seniors in 2000. Factors that increase the risk of falls are: decline in vision, equilibrium, frailty (loss of muscle mass and brittle bones), medication reactions, alcohol use and abuse, incontinence, use of assistive devices, clutter, uneven surfaces, and throw rugs.

Medication management is another risk factor associated with the older adult. Physiological changes of age can interfere with the rate of absorption, metabolism, and elimination of medications. Due to the increased rate of disease, the elderly often visit several different physicians and take multiple prescription medications. Medication interaction can cause adverse reactions: disorientation, risk of injury due to falls, cognitive impairment, and possibly death. The primary problem of medication management is related to compliance. Whether due to problems with memory, confusion, side effects, or the lack of money to buy medications, seniors are often unable to manage their medications. Seniors often misuse, underuse, overuse, or don’t take their prescribed medications. There is also increased risk due to the interaction of alcohol or herbal remedies and prescription drugs.

Another risk that seniors face, due to declining abilities, is isolation. Incontinence and decreased mobility are the key factors for the elder to withdraw from social activities. Without social activities or
social support systems in place the elder at greater risk for all forms of abuse (physical, sexual, psychological, and fiduciary abuse).

Elder Abuse

The most common reports to Los Angeles Adult Protective Services (APS) involving the elderly are cases of self-neglect estimated followed by psychological or emotional abuse, fiduciary abuse, and physical abuse. Abandonment and sexual abuse equal less than 4% of reports. The reports of neglect or self-neglect often involve the elder living in isolation or in unsafe or unsanitary living conditions. Seniors over the age of 75 are the most vulnerable to abuse and neglect due to increased frailty, physical impairment, mental illness, and cognitive decline.

Women tend to be at greater risk of abuse due to their longevity of life. The current life expectancy for women in the United States is 79.4 years. This longevity increases the likelihood of physical and functional decline and increases the likelihood of dependence on others. For this generation of older adults in particular, women have been socialized to be dependent (emotionally, physically, and financially) on others.

Precipitating most forms of abuse is the elder’s physical and mental decline. General characteristics of victims of neglect: 75 years and older, living alone, and frail. General characteristics of victims of psychological abuse: 65 years and older, female, low self-esteem, and usually in good health and physical ability. General characteristics of fiduciary abuse: 75 years and older, physical or cognitive impairment, and dependent. General characteristics of victims of physical abuse: female, dependent, 65 years and older, living with the abuser, predominately Caucasian (estimated at 65%, followed by African Americans 19%), and a history of family violence. Social workers must be cognizant of a sense of powerlessness portrayed by the elder as an indicator of abuse.

Factors that may prevent the abused or neglected elder from reporting abuse or denying the occurrence of abuse include: shame, guilt, fear, or hopelessness. The abused elder may have a fear of being abandoned or being placed in a facility if there is an allegation of abuse. The elder may also be afraid of retaliation by the abuser.

Characteristics of perpetrator of abuse are inconsistent in multiple studies. Indicators of risk to abuse include: substance abuse, mental illness, financial dependence on the elder/victim, caregiver stress, history of violent behavior, and life stressors. The level of dependence by the elder was not an indicator of abuse.

Elder abuse can also be perpetrated by a spouse suffering from cognitive impairments or dementia. The dementia can lead to personality changes and violent outbursts and behaviors toward the caregiving spouse.

Elder Abuse Theories

Caregiver Stress Theory

Caregiver stress theory suggests that stressors on the caregiver cause the caregiver to lash out against the elder. Factors of caregiver stress are: motivation for caregiving, lack of supportive services, lack of coping skills, lack of resources/respite, isolation of the victim, and outside stressors (job, losses, etc.). The level of dependence of the elder is not a factor in caregiver stress.
**Domestic Violence Theory**

Domestic violence theory proposes that the presence of violence is continuous throughout the lifetime of the relationship. Spousal abuse of the older adult is generally regarded as elder abuse as opposed to domestic violence. Elder abuse is more socially accepted than domestic violence. This attitude is reflected in the more lenient penalties of elder abuse laws as compared to domestic violence penalties. This also suggests an attitude that the well being of the older adult is not a priority in this society.

The following are possible signs of abuse downloaded from the Los Angeles County Adult Protective Services website:

- Bruises that are not reasonably explained
- Victim hesitates to talk openly
- Victim is fearful, withdrawn, depressed or highly anxious
- There is an unusual increase in spending of money
- Lack of personal grooming items, appropriate clothing, etc., when the person's income appears adequate to cover such needs
- Family member or caregiver "blames" the elder or dependent adult (e.g., accusation that incontinence is a deliberate act)
- Caregiver has a history of unemployment, substance abuse, mental disorder, or violent behavior
- Accounts of incidents are unreasonable or conflict with explanations by supporters or the victim
- Family/caregiver are reluctant to cooperate with service providers in planning for care

Other indicators of possible abuse:

- Delay in receiving medical attention
- Unusual location of injury
- Burns-cigarette, patterns (iron, curling iron, rope, electric stovetop burner), urine burns and immersion burns.
- Dehydration or Malnutrition
- Pressure Sores
- Pain
- Overmedication or over-sedation
- Poor hygiene
- Signs of possible Depression
- Indications of powerlessness by the elder or caregiver

Social workers are mandated by law to report any suspicions of abuse or neglect/self-neglect towards dependent adults or seniors to the Adult Protective Services Agency. Note: Ethical dilemmas associated with self-determination vs. safety will be addressed in Module 2, SW Practice.

**References**


Major Biological Theories of Aging

**Clock Theory**

The clock theory suggests that the cells have a biological clock. As cells divide the telomeres, which protect the integrity of the chromosomes shorten and deteriorate to a certain length they stop the cell’s ability to reproduce. As cells lose their ability to reproduce new cells the body ages. The theory goes on to suggest that if telomerase activity could be controlled, increasing telomerase production in injuries could speed healing time and decreasing telomerase production in cancer cells could cure the cancer.

**Free Radical Theory**

The free radical theory states that free radicals are molecules with an odd electron, usually associated with oxygen. The free radical disorganizes molecules and converts them into free radicals, destroying chains of molecules. The domino effect of free radicals is instrumental in damaging DNA, proteins, and lipids, and over time the body ages and becomes more susceptible to damage and disease.

**Hormone or Neuroendocrine Theory**

The hormone theory suggests that it is the cessation of the production of hormones that signal the body to begin the effects of aging. Hormones are necessary to the regulation and maintenance of the body. Hormones affect growth, reproduction, muscle mass, and metabolism, to name just a few functions.

**Wear and Tear Theory**

The wear and tear theory implies that the aging process is the accumulation of injuries and damage to the body. Repeated use causes the deterioration of the body coupled with environmental factors increase the risk for disease.

Social Theories of Aging

**Activity Theory**

Activity theory suggests that adults that remain active, physically and mentally, throughout their lives will age successfully. Older adults whose continued participation in social activities, part-time work, travel, and/or hobbies find greater satisfaction throughout their later years. The activity theory disregards the physical and cognitive limitations, disabilities, disease, cultural diversity, and socio-economic status of the elderly.

**Continuity Theory**

The continuity theory states that older adults and society find mutual satisfaction when the older adult continues a consistent level of activity throughout his/her life. The older adult is a continuation of the younger version of him/herself. This theory leaves little room for the older adult to change behavior patterns, learn, and grow. The abused elder may have been abused as a child or younger adult and may be unable to seek help, may feel the abuse is deserved, or may view the abuse as something that cannot be changed due to past experiences.

**Social Construction Theory**
Social construction theory focuses on the uniqueness of each individual’s reality and relates the formation of their reality to their history, experiences, culture, and role identification. It suggests that the person’s experiences and how they view their experiences are more important than their abilities or patterns of adaptation.

**Social Learning Theory**

Social learning theory suggests that behavior is influenced by the social environment the individual is exposed to. If a male child is exposed to parental aggressive or violent behavior as a means of conflict resolution he is more likely to resort to spousal abuse as an adult. If the female child is exposed to parental aggressive or violent behavior as a means of conflict resolution she is more likely to become a victim. The social learning theory suggests that if the elder has a history of violence in the family dynamics there is a greater likelihood of abuse. The adult child while caring for the elder parent may resort to physical abuse to resolve conflicts. The learned behavior as a victim increases the elder’s vulnerability to abuse.

**Social Reconstruction Theory**

Social reconstruction theory is based on the social breakdown syndrome’s view, which suggests society has unrealistic views of the old and labels them as unproductive and useless. Social reconstruction suggests that society’s negative views of the elderly diminish the self-concept and self worth of the older adult. This theory advocates changing the environment of ageism, providing supportive systems for the older adult, and assisting the older adult in regaining control and independence in his/her life.

**Social Disengagement Theory**

Social disengagement theory suggests that there is a reciprocal withdrawal by society and the older adult. The senior withdraws from the social activity due to physical limitations or retirement. Society in return views the older adult as non-productive and having nothing left to offer society.

**Social Exchange Theory**

The social exchange theory suggests that there is a set of mutual expectations that governs our relationships. Successful relationships are based on reciprocal benefit. A parent cares for a child not only out of love but also as an investment for future security in old age. The child in return takes care of the aging parent out of obligation and love. The elder with limited physical and cognitive abilities often can offer little in return for the care that is needed to sustain them. The stress of caregiving can sometimes outweigh the sense of obligation or love that a caregiver feels causing an imbalance in the reciprocal benefit, leading to caregiver burnout. As the frustration of caregiving increases so increases the risk of abuse, abandonment, or neglect.

**Developmental Theoretical Frameworks Applied to the Older Adult**

**Attachment Theory**

Bowlby’s attachment theory discusses the importance of early childhood attachments to primary caregivers to provide a secure foundation from which the child can explore his/her physical environments and social engagements. Secure attachments are associated with higher self-esteem and sense of well-being. The attachment theory can be applied to the older adult’s reaction to stress (physical, environmental, and loss) and their ability to cope. Attachment behavior patterns are often broken down into three categories: secure, avoidant, and anxious. Securely attached personalities will seek out interaction, during times of great stress, in either support seeking or support giving behaviors. Avoidant personalities tend to be wary or mistrustful of intervention by others, preferring to depend on themselves. Anxious personalities tend to become more dependent on others giving up their autonomy.
The attachment theory may indicate whether the abused or neglected elder will seek help from support systems, isolate him/herself, or become dependent on others. All three personality types can become victims of self-neglect and/or abuse. The risk may be higher for the avoidant and anxious personalities. The avoidant personality may be more resistant to intervention and the anxious personality may be more at risk for all forms of abuse due to their dependence on others. Experts in the field of trauma report the most important factor in recovery of traumatic events is the ability to seek comfort in others.

The attachment theory is also important in viewing caregiving patterns of the adult child now providing care for their elderly parents. Attachment theory is also integral in the ability of adults to form loving relationships throughout the lifespan and can be reflected in the elder adult providing care for a spouse.

**Cultural Perspective**

Culture is a set of beliefs, role identifications, behavioral patterns, values, and traditions that are passed from generation to generation. Due to the diversity of people it is imperative to use a perspective that acknowledges the effect of culture on the behavior of the elderly. It is also important to acknowledge the time of immigration, bi-culturation, and historic events that impact cultural groups. Cultural expectations and views of successful aging vary in different ethnicities and social workers must be culturally competent and aware of the differences but must not stereotype the individual by culture, ethnicity, or age. For example, Asians view old age as a time to decrease activity; they find contentment in the revered position of having lived a long and fruitful life. Westerners generally view successful aging with how much activity can be sustained from the middle adulthood stage of life. Cultural definitions of abuse vary. Asians and Hispanics generally tend to view abuse as a private family matter and avoid outside intervention. African Americans are more likely to seek legal intervention. Due to the cultural difference victims of elder abuse may not recognize the abuse as abuse or may be too ashamed to admit that abuse is occurring. Language is another key factor that can inhibit an abused elder from seeking help.

**Ecological Perspective**

The ecological perspective acknowledges the impact that the environment has on the individual. For the older adult, the influences of the social environment can be seen the lack services and resources provided for the continued independence of the elderly. Affordable housing, transportation, and medications are often a problem for the elderly who are often living on a fixed income. Poverty continues to be a major problem for the older adult. Poverty rates increase with age from 10.5% at 65 years of age to 14.2% for 85 years and older in the United States.

**Erickson’s Developmental Milestones**

Erickson recognized that human development continues throughout the life span and defined the tasks of each stage of life in terms of crises. Erickson suggests that the crisis of old age is ego integrity versus despair. This stage of life is characterized as a time of reflection and accepting of one’s life. Ego integrity is the positive self-review one’s accomplishments and failures and the acceptance of both. People with ego integrity are able to resolve crises and have a sense of peace and acceptance of death. Despair is the negative self-review resulting in regret, self-contempt, and a fear of death.

**Health Perspective**

The health perspective looks at the individual’s concepts of aging, health, well-being, healthcare, and medications usage. This perspective is important when assessing the older adult’s attitudes towards aging, the presence of disease, pain, and physical or cognitive declines. It is important to remember that not all seniors have had the same benefits or access to a lifetime of medical care.
**Life Course Perspective**

The life course or life span perspective views life as being fluid, multifaceted, contextual, and life-long in development and growth. This perspective states that old age is the culmination and continuation of life experiences, social roles, transitions, history, and adaptations. The life course perspective views old age as a positive period of continued growth as opposed to equating aging to decline or regarding aging in the disease model.

**Maslow’s Hierarchy of Needs**

Maslow’s Hierarchy of Needs states that to reach self-actualization basic needs must first be met. In working with the older adult this framework can be useful in determining whether there are indications of neglect or abuse. Is the elder’s basic needs being met? Is the elder safe? Is the elder isolated?

**Strengths Perspective**

The strengths perspective evaluates the abilities, skills, and motivation of the older adult. This perspective focuses on identifying the adaptive abilities and coping mechanisms of a lifetime of events and utilizing these strengths to achieve the client’s goals. Although the focus is on the strengths of the client it is important to acknowledge their limitations so that the mutually agreed upon interventions are attainable.

No matter what perspective or theory is engaged, a positive attitude towards the aging process and the elderly is important, as it will affect how we view the abilities of the client.

**References**


Case Vignette: Elder Abuse

Ms. G. is a 79 year old, African American female who lives alone in a trailer. The trailer does not have a functioning shower or toilet. Ms. G uses the facilities behind the garage, approximately 25 feet away. At the time of the initial assessment, she was dressed in a soiled loose nightgown and her hair was not combed. The trailer was dirty, unkempt, and strewn with candy wrappers. Ms. G was alert and oriented X5 but appeared guarded and suspicious. Ms. G was referred to case management, by Adult Protective Services (APS), due to an eviction notice.

Ms. G is a widow and has one surviving son who lives in a mental health facility. She reports no affiliation with religious organizations, family, or friends. Ms. G reported she completed the 9th grade and worked as a nurse’s assistant at a retirement home. She reported she would rather die than go into a home. Ms. G reported Supplemental Security Income (SSI) $721.00 as her only source of income. Her monthly rent for the trailer is $400.00.

Ms. G has a history of diabetes, hypertension, and CVA (stroke). The CVA has left her with partial paralysis on the left side of her face and minimal weakness on the left side of her body. Ms. G does not regularly attend medical check-ups and is frequently hospitalized due to high sugar levels. She is non-compliant with her medications. She has visiting nurses administer her medications twice daily, but she frequently misses her medications when she is out. She is at risk of losing the service of the visiting nurses because she does not notify the agency if she is going to be out and has had complaints of being belligerent.

Ms. G scored a 19/30 on the Folstein Mini Mental Status Examination (MMSE) and a 3/15 on the Geriatric Depression Scale. She reported she is able to complete all Activities of Daily Living (ADLs) and Instrumental Activities Daily Living (IADLs) independently. Ms. G’s mobility is slow and unstable, and she has difficulty transferring. She has reported two falls in the last 6 months. Ms. G is unable to manage medications, manage money, or the use of a telephone without the assistance of another. She is able to use public transportation.

Human Behavior
What biological, psychological, and environmental factors are affecting the client? 
What stressors are affecting the client? What is her normal level of stress? Is chaos status quo? 
Is judgment the same as cognition? 
Is Ms. G’s judgment impaired? Is she cognitively able to make decisions?

Practice Implications
What are the client’s strengths? What are the personal historic events that the client has survived (death of her husband, death of her 1st son, surviving son in mental institution) 
Are there indications of abuse, neglect, self-neglect? 
What are the risks to the client’s safety? 
Ethical considerations: Safety vs. Autonomy 
What does in the best interest of the client mean? How does this apply to Ms. G? 
Is Ms. G safe to continue to live independently? What are the risks to her independence? 
Does Ms. G’s admission “I’d rather die than go into a home” indicate a mandated reporting issue?

Policy Issues
What resources are available to the client? Home Health, Supplemental Security Income (SSI), Medicare, MediCal 
Services needed by client? In Home Supportive Services (IHSS), HUD Section 8 Housing? 
What resources are needed? What would she be eligible for if her income was $1,000.00 per month? 
What policy changes are required to reflect the needs of the aging population? 
Social Security, Medicare, Prescription Drugs, Universal Healthcare Coverage, Long-term Care, Euthanasia/Right to Die, Affordable Housing, Intergenerational Prevention Programs