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Volume 7, Number 17 **August 20, 2001**

Elder Mistreatment—Part I: Primary Care Assessment and Management

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And that which should accompany old age,
As honour, love, obedience, troops of friends,
I must not look to have; but, in their stead,
Curses, not loud but deep, mouth-honour, breath
Which the poor heart would fain deny, and dare not.—
William Shakespeare.

Editor's Note—*In this issue, the reader will be presented with an introduction and history of elder abuse along with discussions of etiology, incidence, and prevalence, cultural considerations, a delineation of types of abuse, and case studies. Part II of Elder Mistreatment: Primary Care Assessment and Management will offer an overview of patient presentation, assessment & diagnosis (including physical exam & laboratory evidence), mandated reporting, advocacy, and prevention. Numerous resources for physician, patient, and caregivers are provided in appendices.*

Introduction

Elder abuse exists subset to the broader social maladies of interpersonal violence and neglect. Domestic violence and the morbidity and mortality of elder abuse represent a compelling health care issue. Even after controlling for demographics, chronic disease, cognitive status, and other known risk factors for mortality, elder mistreatment remains an independent risk factor associated with shorter survival.[1] The primary care physician (PCP) must be vigilant to the signs and symptoms of elder abuse, neglect, and self-neglect as they may present in both institutional and noninstitutional settings. The following report will review the history and epidemiology of this concern as well as offer the PCP practical tools to identify, treat, and provide advocacy for all affected parties.

History

Elder abuse is not limited to Western cultures in the post-industrial era. The literature of classical antiquity references elder abuse frequently. For example, Cicero (106 BC-43 BC) in his tome *On Old Age* wrote:

"Sophocles composed tragedies to extreme old age; and being believed to neglect the care of his property owing to his devotion to his art, his sons brought him into court to get a judicial decision depriving him of the management of his property on the ground of weak intellect—just as in our law it is customary to deprive a paterfamilias of the management of his property if he is squandering it. Thereupon the old poet is said to have read to the judges the play he had on hand and had just composed—the Oedipus Coloneus—and to have asked them whether they thought that the work of a man of weak intellect."

In the Roman Republic, elder neglect prompted the passage of the law of *Lex Ciconaria* (Stork's Law) requiring children to support their parents in old age. Neither were non-Western cultures exempt from mistreating elders. Sir James Frazier, in his book *The Golden Bough*,[2] wrote that African tribes of the 17th-20th centuries were noted by Western

observers to put elders (especially rulers) to death when they had outlived their usefulness. Frazier reported similar customs among Cambodians, where rulers were killed when they became aged and/or ill.

A US history perspective, however, suggests that elder mistreatment may not have been well tolerated during colonial times—at least not among the privileged. Indeed, achieving old age was believed by many to be demonstrative of being in favor with God.[3] The aged were often afforded high privilege and status within the community; meeting house seats, for example, were commonly assigned by age with elders occupying the seats of highest regard.[4] It should be recalled that pre-19th century America was largely an agrarian society and parents typically controlled property well into their advancing years or until their death allowed the transfer of property to heirs. Property was wealth and power and these conditions of state endowed privileged elders with considerable power and status. Thus, it would not have been prudent to disenfranchise one's hoped-for benefactor. It should be noted, however, that not all colonial elders enjoyed such status and deference. The plight of the colonial widow, elder African American (many of whom were slaves or indentured servants), and frail/ill elder were by no means enviable conditions.[3]

By the late 1800s, colonial American society gave way to the changes in socioeconomic conditions, technologies, and cultural values generated by the American Industrial Revolution. Conditions altered sufficiently to degrade the status of elder and exalt that of youth. Urban growth and industrialization provided a new freedom and avenue for achieving financial independence and prosperity—consequently diminishing the power of parental control of land.[5] Increased lifespans also left many elders without reliable sustainable incomes; old age often became both a burden to live and a burden upon caregivers and society.[3] Indeed, the plight of the impoverished elder spawned 19th century social movements for government furnished pensions (forbearers of Social Security).

Etiology

While it is feasible that elder abuse is simply one additional manifestation of aggression within our society,[6] a number of theories seek to explain the underpinnings of elder abuse and mistreatment. At least 4 are reliably repeated throughout the literature. The **social exchange** theory focuses upon power imbalances, whereby it is often the abusing caregiver's dependency (particularly financial dependency) upon a frail elder that proves critical toward bringing about conditions of neglect and/or abuse.[3,7-9] The **stressed caregiver** theory holds that the accumulated burdens of caring for an elder (especially one who is severely dependent or otherwise difficult to assist) eventually brings about an exhaustion that leads to the caregiver perpetrating abuse and/or neglect.[3,7,8,10] The theory of **intergenerational transmission** essentially proposes a "cycle of violence" whereby the one-time abuser becomes the abused (ie, the parent who had at one time mistreated their child is served a reciprocity of sorts, also known as "family retaliation theory").[3,7,8,10] **Caregiver pathology** is also proposed as sufficient for bringing about conditions that lead to elder abuse and neglect (eg, psychiatric illness and/or alcohol/substance abuse on the part of the caregiver).[7,8,10]

Regarding postulates of self-neglect, there is considerable agreement for this being a most vague and poorly defined condition in which no single causal model dominates.[11-13] Biopsychosocial interactions of disease, individual, and environment have been proposed.[12] Dementia has also been specifically implicated.[14] One of the most promising etiological theories, however, may reside with research investigating the component elements necessary to achieve self-care. Lauder hypothesized that individuals who self-neglect have less self-care agency (ie, the capacity and disposition to engage in self-care activities necessary to sustain good health).[15] In adopting this premise, Lauder borrowed from an earlier theory of self-care, which maintains that self-care is a function of self-care agency —the link between self-care needs and self-care action.[16] Lauder found that low indices of self-care agency (as measured by the Self-Care Agency Scale)[17] differentiated self-neglect patients from a non-neglect comparison group ($P < .0001$) in which no single medical diagnostic condition was capable of the same.[15]

Cultural Considerations

One would be remiss to discount the multicultural milieu of elder treatment (and mistreatment) as well as the bearing culture may have upon accessing social services. Hispanic persons, for example, have generally incorporated a value set that places at premium the multigenerational life of the family; adult children are expected to demonstrate respect for and attend to their elders' needs.[18] As ideal as such mores may

Primary Care Reports™, ISSN 1040-2497, is published biweekly by American Health Consultants, 3525 Piedmont Rd., NE, Bldg. 6, Suite 400, Atlanta, GA 30305.

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GST Registration Number: R128870672.
POSTMASTER: Send address changes to ***Primary Care Reports***™, P.O. Box 740059, Atlanta, GA 30374.

Periodical rate postage paid at Atlanta, GA.
Back issues: $23. Missing issues will be fulfilled by Customer Service free of charge when contacted within one month of the missing issue's date.

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Statement of Financial Disclosure

In order to reveal any potential bias in this publication, we disclose that Dr. DeLaGarza (author) serves on the speaker's bureau and is a stockholder of Pfizer and Novartis. Dr. Meit (author) reports no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

appear, where difficulties do exist, it is also a cultural expectation to attend to needs and address problems within the family—outside help and resources are rarely sought.[18,19] African-Americans, with an almost archetypal history of being subjected to racial violence, are often reluctant to access and/or trust social services for different reasons.[20] This condition further isolates many elder African-American women who, all too often, are pressed upon to provide for (many times to the point of exploitation) the young adult members of their family and extended family.[20] Regarding Asian-Americans and the inculcates of far Eastern cultures, there is a powerful sense of shame associated with poor familial relations. Honorable and dignified conditions are expected and persons from such cultural backgrounds will typically endure much suffering rather than expose themselves to the public eye.[21,22] For Native Americans (where elders typically ascend to positions of leadership and are afforded much respect), it is important to appreciate that where elder abuse is identified, it is considered to be a problem of the tribal community.[23] Such realities may require a more expansive systems intervention than the average practitioner is accustomed to (moving well beyond nuclear or even extended family domains). Further, the strong cultural prohibitions and taboo against mistreating elders can make detection and identification of abuse conditions particularly challenging.[24]

Scope of the Problem

Graying of the Nation

Elders (defined by the National Center on Elder Abuse as those older than 60) represent the fastest growing segment of our society. While representing 13% of the US population in 1990, projections estimate that the elder population will expand to 18% by 2020[25] and 70 million persons by 2030.[26,27] Seventy million elders represent no less than *twice* the number of older Americans present in 1990.[26] Indeed, the "oldest old" (those older than 85 years) age group is increasing faster than any other age group.[28] Not only will we bear witness to dramatic changes in age cohort distributions, the aging "face" of the nation will increasingly reflect an expanding diversity. The Assistant Secretary of Aging (US Department of Health and Human Services) reports that by the year 2020, the number of elderly Hispanic Americans is expected to increase by 300% (compared to 1998 point of reference); elderly African Americans by 102%; and elderly Asian and Pacific Islanders by 358%.[29] It is notable, then, that a relatively recent review of the Index Medicus (covering a 5-year segment), identified only 26 elder abuse citations (as opposed to 248 child abuse citations).[30] Some of this paucity of investigation may rest with the difficulties inherent in defining what constitutes elder abuse and neglect; some may lie with our country's reluctance to relinquish its favor for youth despite the changing face of the nation.[31] Regarding the latter possibility, the reader is invited to view Figure 1 to discover which woman is most easily perceived by their "mind's eye."

Incidence and Prevalence

It is critical to recognize that, like child abuse and partner abuse, elder abuse and neglect occurs across all socioeconomic, cultural, and societal groups.[6,32,33] The accuracy and reliability of incidence/prevalence data, however, remains hampered by varying definitions of elder abuse/neglect, differences in state laws, and reluctance to report (on the part of providers, family and friends, and the victims themselves).[9,34-36] The National Elder Abuse Incidence Study, however, reports that at least half a million noninstitutionalized elders (age 60 and older) were abused and/or neglected in 1996; more than 100,000 additional persons suffered from self-neglect.[37] Further, there is evidence (largely obtained via "sentinels"—specially trained individuals reporting from a variety of community settings, such as senior centers) that for every reported incident, 5 go unreported.[37,38] The US House of Representatives' Select Committee on Aging estimates that as many as 2 million elder Americans suffer from some form of abuse/neglect each year.[39] Prevalence estimates range from 1.3% to 10%.[37,40-43]

Definitions

As noted, definitions of elder abuse and neglect have often lacked consistency. This has certainly contributed much of the

Figure 1. Youthful or Aged?

Based on a classic illustration attributed to Edwin Garrigues Boring, PhD. Boring (b. Oct. 23, 1886, d. July 1, 1968) was an accomplished experimental psychologist in the areas of sensation, perception, and cognition and a president of the American Psychological Association (1928). He may be best remembered, however, as a premier historian of the discipline of psychology.

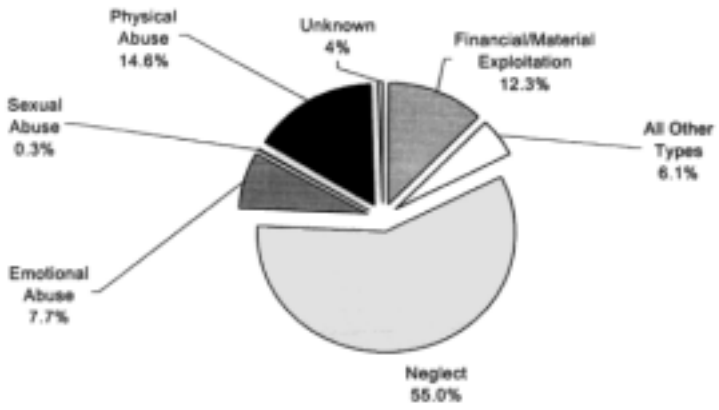
variability observed in incidence/prevalence data, social, civic, and health care policy, as well as legal statutes across the country. The American Medical Association (AMA) defines elder abuse/neglect as "an act or omission which results in harm or threatened harm to the health or welfare of an elderly person." Abuse includes the "intentional infliction of physical or mental injury, sexual abuse, or withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person by one having the care, custody, or responsibility of an elderly person."[44] This definition, published in a report by the AMA's Council of Scientific Affairs, also introduced the concept of categories of abuse such as "violation of

Table 1. Definitions

Abuse	Definition	Example
Physical abuse	The use of physical force that may result in bodily injury, physical pain, or impairment.	Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. The unwarranted administration of drugs and physical restraints, feeding, and physical punishment of any kind also are examples of physical abuse.
Sexual Abuse	Nonconcensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent also is considered sexual abuse.	Includes but not limited to unwanted touching, all types of sexual assault or battery such as rape, sodomy, coerced nudity, and sexually explicit photographing.
Emotional or psychological abuse	The infliction of anguish, emotional pain, or distress.	Verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from family, friends, or regular activities; giving an older person a "silent treatment;" and enforced social isolation also are examples of emotional or psychological abuse.
Neglect	The refusal or failure to fulfill any part of a person's obligations.	Failure by a person who has fiduciary responsibilities to provide care for an elder (eg, failure to pay for necessary home care service, or the failure on the part of an in-home service provider to provide necessary care). Failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included as a responsibility or an agreement.
Abandonment	The desertion of an elderly person by an individual who has assumed responsibility for providing care or by a person with physical custody of an elder.	Leaving older persons alone who are unable to care for themselves.
Financial or material exploitation	The illegal or improper use of an elder's funds, property, or assets.	Cashing checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing a document (eg, contracts or a will); and the improper use of conservatorship, guardianship, or power of attorney.
Self-neglect	Characterized as the behaviors of an elderly person that threaten his or her own safety.	Self-neglect generally manifests itself in an older person's refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, safety, personal hygiene, and medication.*

* The NCEA's definition of self-neglect excludes a situation in which a competent older person makes a voluntary decision to engage in acts that threaten the person's well-being.

Figure 2. Types of Domestic Elder Abuse (1996)



Source: *Reprinted with permission from the National Center on Elder Abuse web site (www.elderabusecenter.org).*

rights"—defined as the prevention of an older person from exercising rights normally available to adult citizens. Another category was medical abuse—the withholding or administering of inappropriate medication or treatments.[44] A more recent policy statement, by the American College of Emergency Physicians (ACEP), asserts: "Mistreatment of elders includes neglect, physical abuse, sexual abuse, emotional abuse, financial or material exploitation, abandonment, and self-neglect. It may be intentional or unintentional."[45] The National Center on Elder Abuse adopts these same indications of abuse and neglect.[41]

Abuse Categories

Physical abuse may be defined as the use of force for the purpose of inflicting pain or to deprive an older person of their rights. It can be either intentional to create fear, change behavior, or compel compliance, or unintentional as what might happen in an impulsive manner. Sexual abuse is nonconsensual intercourse or genital touching. Emotional abuse occurs when actions are designed to cause anxiety, dysphoria, and/or fear in the older person. Financial exploitation occurs when an older person's property or monetary assets are appropriated against his or her interests. Neglect and abandonment happen when a person fails a duty or obligation to meet an older person's needs, or deserts an older person. Self-neglect is defined as behaviors of an older person that threaten their own safety or health. Table 1 summarizes these definitions. Statistical data assembled by the National Center on Elder Abuse (NCEA Elder Abuse Information Series No. 1, 1999) reveals elder neglect to be the most common form of mistreatment (55% of substantiated cases, not including instances of self-neglect) (*see Figure 2*).[46]

Abuse may occur at home or in institutions. Although most reports deal with mistreatment within domestic settings, accounts of institutional abuse began appearing in the medical literature, press, and tabloid television shows during the 1980s. While it may be argued that lay press communications lack the rigors of empiricism common to scientific journals, their influence upon the collective American conscience cannot be denied. The following is an excerpt from a 1989 *Washington Post* article:

"Behind the walls of some American nursing homes, mice nest in the hair of once-dignified ladies and forgotten people drown in bathtubs. These are not threadbare stories from a less enlightened era. They are fresh accounts of the abuse that still goes on in many nursing homes, where the elderly pay for care and attention and instead get neglect and intimidation."[47]

The reporting of abuse in nursing homes was partially responsible for the Nursing Home Reform Act of 1987 (also known as OBRA 1987; abbreviated from the name of the law—Omnibus Budget Reconciliation Act). This comprehensive law stipulates the manner in which residents are to be treated (both medical and nursing treatment), and deals with the safety and well-being of the institutionalized nursing home resident.[48] Federal law also mandates a system of ombudsmen who are responsible for ensuring the safety and treatment of nursing home residents; evidence suggests that such involvement/scrutiny has increased abuse reporting, case substantiation, and remedial action.[49] As a consequence, nursing homes are now considered to be one of the most regulated industries in the United States. A summary of OBRA rules is listed in Table 2. Personal care homes and assisted living facilities are regulated by the states and, as a general rule, are subject to much less government oversight. The prevalence of abuse in these types of institutional settings is largely unknown.

In day-to-day clinical practice, it can often be difficult to determine whether abuse has genuinely occurred—either in the home or institutional setting. Given the difficulty of such judgments, case examples can be illustrative. The following cases were obtained from the Geriatric 65 Plus Clinic of the West Virginia University Health Sciences Campus.

Cases

Physical abuse. Mrs. S. was a 79-year-old woman with moderately severe Alzheimer's disease. She was widowed and lived with her son, daughter-in-law, and their child in the patient's 4-bedroom house. The daughter-in-law and son were her caregivers and had adequately provided for all of her needs. Although she was dependent in most basic activities of daily living, she remained ambulatory and was able to feed herself. Unfortunately, she insidiously developed a common disturbed behavior associated with Alzheimer's disease—persistent vocalization. Patients with this behavior call out constantly and cannot be convinced that their behavior or request(s) are illogical. In her case, she called out continuously for her mother in an insistent tone. The pleading and demands for her mother occurred most of the day and could not be controlled with varying pharmacological treatments. Eventually, the behavior became so pervasive it disrupted the sleep of her caregivers. Finally, the son (after a frustrating day at work and several consecutive sleepless nights) lost his temper and hit his mother in the face. Several of her teeth were fractured. Following treatment in a dentist's office, the patient was transferred to a nursing home.

Mr. N. had resided in a nursing home for several years. His Alzheimer's disease had progressed to the point in which his

judgment was poor and osteoarthritis of his knee produced significant lower extremity weakness. Insidiously, he began falling and injuring himself. In order to protect him, the nursing staff restrained him with a vest device to a chair for most of the day. After several days, a delirium developed and was characterized by hallucinations and screaming. This prompted the nurses to ask for medication from the attending physician to control his agitation, which caused sedation but made it easier for the staff to manage him. The use of the restraints was discovered by the medical director at a quality assurance meeting and prompted a staff in-service on the topic of fall prevention. The patient was weaned off of psychotropics, but he never regained his previous level of functioning.

Sexual abuse. Mrs. W. is an 81-year-old woman with multi-infarct dementia residing in an assisted living facility. She is ambulatory with a walker, though she requires assistance with other basic activities of daily living (ADLs). One evening, the nurses at the facility noted that a male resident with Alzheimer's disease had entered her room and was in her bed fondling her. At the family's request, the patient was brought to the emergency room for evaluation. On exam, there was no evidence of genital penetration or venereal disease. The patient was interviewed and evaluated the next day in the geriatric clinic, however, and found to lack sufficient cognitive capacity to consent to such activity. As a consequence of the incident, nursing procedures at the assisted living facility were modified to enable closer supervision of residents.

Emotional abuse. Mrs. S. is an 83-year-old widowed woman who requires assistance with most of her basic activities of daily living, furnished by her single daughter. After presenting to the medical clinic with a number of somatic complaints consisting of dizziness, insomnia, and anorexia, a history that revealed conflict became apparent. The elder woman and her daughter had different tastes in television entertainment; to gain control of the television, the daughter continuously threatened to place her mother in a nursing home. The daughter denied that she was serious about her threats, but the mother went on to communicate what can only be described as absurd and hideous descriptions of nursing homes—in explicit detail. Professional counseling services were arranged for this family.

Financial exploitation. An 86-year-old single woman was convinced to sell her home to her next-door neighbor in return for a number of errands that had been completed on her behalf. She was assured that she would be able to remain in the house until she died. However, some 9 months after selling her home, she was told she would be evicted. The sheriff refused to remove the elder and alerted an attorney who contacted our geriatric clinic. We arranged to evaluate the woman within the week. Our evaluation discovered that she was mildly demented, seriously depressed, and easily intimidated. Following a communication from the attorney, the neighbor returned the house to the patient.

Neglect. A 69-year-old man, unhappy with the care his 92-year-old severely demented bed-ridden mother was receiving in a nursing home, removed her from the facility. He converted an upstairs bedroom in his home and began to care for her. Although he had assistance with visiting nurses and home

Table 2. OBRA Rules

Resident Rights	Examples
The resident has a right to a dignified existence, including access to persons inside and outside the facility.	A nursing home cannot restrict visitors.
The resident has the right to be informed of his or her medical condition and the right to refuse treatment. A facility cannot discharge a patient for refusing treatment.	
The resident may choose his or her physician.	
A facility may not use restraints for the purpose of discipline or convenience.	A nursing home cannot restrain a patient to a chair while personnel are busy in other areas (eg, serving meals).
The resident has the right to be free from physical or verbal abuse, or involuntary seclusion.	Residents cannot be hit or shouted at. Nor can they be confined to their room simply because the staff dislikes the resident's personality.
The facility must include a comprehensive multidisciplinary evaluation of the patient and must institute appropriate treatment for those conditions found.	In nursing homes, a document called the Minimum Data Set is required on all new admissions. This addresses the functioning of the patient in 18 different areas. Thus, a resident found to have a hearing loss and leg weakness must have these deficiencies addressed and would be seen by an audiologist, physician, and physical therapist.
Psychotropic medication must not be used for convenience, but must have a medical diagnosis.	A resident who has a habit of staying up late cannot be given a sedative to lessen the need of the staff to supervise him or her. In addition, there are documentation, dose, and duration guidelines for psychotropic drugs.

aides, he quickly found that he did not have the physical strength to turn his mother frequently enough to avoid decubitus ulcers. The son refused to move his mother to a nursing home despite nurses' requests. Multiple grade-3 decubiti quickly developed, prompting the home health nurses to notify the county Adult Protective Services (APS). APS arranged for hospital admission and, after several days, she was transferred to a nursing home.

Abandonment. An 80-year-old widower with severe painful osteoarthritis of the knees gradually became unable to shop or cook for himself. He relied on his 2 sons and daughter for meals and housework. Although his children created a rotation system aimed at meeting his needs, they became resolute in their desire to move him to an assisted living facility. The elder father was just as firm in his opposition to such a plan. He stated that he would die in his home rather than go to a nursing home. Furthermore, he refused to accept the aid of hired caregivers. After several frustrating months, the children decided that they would show their father that he could not care for himself by stopping their services. For 1 week, the children did not telephone or come to his house. After several days, a neighbor (concerned that there had been no lights on in the house for several days) entered the home and found the man lying on the floor with a hip fracture. After hospital treatment of the hip fracture and associated renal failure, the patient was transferred to a nursing home. He died at this facility 2 years later.

Self-neglect. An 87-year-old woman was brought for medical care by a neighbor who was concerned that the patient had stopped cooking for herself. In bringing food to the woman, the neighbor also noted that the elder woman had poor hygiene. The neighbor managed to have the patient seen in clinic on the pretense of "having a physical." On interview in the clinic, the patient denied anything was wrong but it was noted that the patient was unkempt and her clothes were unwashed. The physical exam revealed a significantly underweight woman and was also remarkable for candidiasis under the breasts, stool in her undergarments, and significant osteoarthritis. The patient also had a significant Geriatric Depression Scale score. With initiation of antidepressant therapy (monitored by the neighbor and nurse home visits), the patient made a gratifying improvement.

Hopefully conveyed by way of these case descriptions, is the fact that true malice is not a necessary condition for elder abuse and/or neglect to occur. Poor judgment and inexperience in recognizing and meeting the needs of elders are more commonly the culprit causal factors.

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Physician CME Questions

9. All of the following have been postulated as causes of elder mistreatment *except*:
   a. caregiver stress.
   b. cycle of violence.
   c. caregiver pathology.
   d. elder financial dependency.
   e. power imbalances.

10. The final report of the National Elder Abuse Incidence Study concluded that at least a half million Americans living in domestic settings were victims of abuse and/or neglect in 1996. For every reported incident, how many are believed to have gone unreported?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5

11. The most common form of elder mistreatment (apart from self-neglect) is:
   a. physical abuse.
   b. financial exploitation.
   c. neglect.
   d. sexual abuse.
   e. psychological abuse.

12. What percent of abuse reported to adult protective services is substantiated?
   a. Less than 5%
   b. 10-20%
   c. 40-60%
   d. 70-80%
   e. > 90%

In Future Issues:

Elder Mistreatment: Part II—
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