Risk Factors for Elder Abuse

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The results of the first national incidence study of noninstitutionalized elder abuse and neglect in the United States are reviewed, as well as underlying causes of abusive relationships involving the elderly. It is estimated that approximately 1% to 2% of elders living in their own homes became abused in the United States during 1996, physically, emotionally, sexually, and/or financially. The abusers were predominantly adult children, spouses, and other relatives. More than 5 times as many new incidents of abuse and neglect were unreported than those reported to authorities responsible for addressing elder abuse. An individual who abuses an elder is often financially dependent on the elder, violent in other contexts, abuses alcohol and/or drugs, and has psychological problems. Although current rules and practices constrain the underwriting professional’s use of this information in risk selection, public demand for financial institutions’ reporting of elder abuse may provide an opportunity for open discussion about responsible handling of such cases.

Within recent years, the insurance industry has turned to the elder market as a potentially lucrative source of business. Insurance products of interest to elders include life insurance, long-term care insurance, and annuities. Since the underwriting of elders is different than that for younger ages, a great amount of education has been rapidly undergone by underwriting professionals to understand the unique risks presented by the elderly. This education is being conducted in parallel with efforts made in the general population to learn more about elders, the fastest growing demographic segment.

The results of such efforts will influence public policies on retirement, health care, housing, and other needs. The insurance industry can expect to receive demands by the public to support social policies intended to improve the quality of life of the elderly. Social policies addressing abuse of the elderly are currently being improved on the basis of information that is becoming more accurate and reliable. This article summarizes the results of a new US study that provides a benchmark defining the magnitude of the problem of elder abuse in domestic settings. Attributes of the victims and abusers are also described, which can serve to better detect situations in which elders are at excess risk of abuse.

The ability of underwriting professionals to use this new information may be limited at present, although they now can become better prepared to identify cases of elder abuse. Insurers improve their risk selection practices on the basis of the availability of information that is necessarily quantitative in nature and
high in quality. The ability to withstand oversight by regulators and consumer advocates, and challenges in court is one of many criteria against which these risk selection practices are judged.

Underwriting professionals are constrained by the rules and practices governing the insurance industry in applying any information that enhances their risk selection practices. The public may not often be aware of this situation or may take different positions according to a shifting pattern of interests. Insurers’ roles as knowledgeable and respected resources for healthy lifestyle advice are well established, but the definition of responsible behavior in handling individual cases of elder abuse needs further discussion within the insurance industry and with the public.

THE NATIONAL ELDER ABUSE INCIDENCE STUDY

Like other types of domestic violence, knowledge about elder abuse until recently has been based on relatively small groups and thus was tenuous in nature. Attempts to generate national data on domestic elder abuse in the United States relied on state-compiled statistics of suspected abuse, with considerable variations in definitions and comprehensiveness of reporting systems. To remedy this situation, in 1992 Congress enacted the Family Violence Prevention and Services Act (Public Law No. 102-295), which directed that a study of the national incidence of abuse, neglect, and exploitation of elderly persons be conducted. The National Elder Abuse Incidence Study (NEAIS) was conducted, and its final report became available in September 1998.1

The NEAIS gathered data on domestic elder abuse, neglect, and self-neglect through a nationally representative sample of 20 counties in 15 states. For each county sampled, the study collected data from 2 sources: (1) reports from the local Adult Protective Services (APS) agency responsible for receiving and investigating reports in each county and (2) reports from “sentinels,” specially trained individuals in a variety of community agencies who had frequent contact with the elderly. Community sentinels included individuals from law enforcement agencies, hospitals, elder care providers, and banks. The study did not examine elders housed in institutional settings such as nursing homes and other licensed adult care centers; these have their own systems of oversight for detecting and responding to abuse and neglect.

Overall, the findings of the NEAIS confirmed the commonly held theory that officially reported cases of abuse are only the “tip of the iceberg” or a partial measure of a much larger, unidentified problem. The best national estimate based on the study findings is that a total of 449,924 elderly persons, aged 60 years and over, experienced abuse and/or neglect in domestic settings in 1996. Since there were approximately 44 million persons in the United States aged 60 and over in 1996, this estimate represents approximately 1% to 2% of the US population over age 60. Of this total, 16% were reported to and substantiated by APS agencies, but the remaining 84% were not reported to APS.

DEFINITIONS, SIGNS, AND SYMPTOMS

To achieve standardized definitions of elder abuse and neglect within the NEAIS, a process was completed involving the comparison of state definitions, local professional roundtables, and consensus meetings. The final definitions were then promulgated with the use of written and video training materials among the APS and sentinel participants in the study areas.

Physical abuse was defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to acts of violence such 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, force-feeding,
and physical punishment of any kind are also examples of physical abuse.

Signs and symptoms of physical abuse include the following:

- Bruises, black eyes, welts, lacerations, and rope marks
- Bone fractures, broken bones, and skull fractures
- Open wounds, cuts, punctures, untreated injuries, and injuries in various stages of healing
- Stains, dislocations, and internal injuries/bleeding
- Broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained
- Laboratory findings of medication overdose or underutilization of prescribed drugs
- An elder’s report of being slapped, hit, kicked, or mistreated
- An elder’s sudden change in behavior
- A caregiver’s refusal to allow visitors to see an elder alone

Sexual abuse was defined as nonconsensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent also is considered sexual abuse; it includes but is not limited to unwanted touching and all types of sexual assault and battery such as rape, sodomy, coerced nudity, and sexually explicit photography.

Signs and symptoms of sexual abuse included the following:

- Bruises around the breasts or genital area
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained, or bloody underclothing
- An elder’s report of being sexually assaulted or raped

Emotional or psychological abuse was defined as the infliction of anguish, pain, or distress. Emotional or psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. Other examples of emotional or psychological abuse include 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.

Signs and symptoms of emotional or psychological abuse include the following:

- Emotional upset or agitation
- Extreme withdrawal and noncommunication or nonresponsiveness
- An elder’s report of being verbally or emotionally mistreated

Financial or material exploitation was defined as the illegal or improper use of an elder’s funds, property, or assets. Examples include but are not limited to 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.

Signs and symptoms of financial or material exploitation include the following:

- Sudden changes in a bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying an elder
- The inclusion of additional names on an elder’s bank signature card
- Unauthorized withdrawal of funds using an elder’s ATM card
- Abrupt changes in a will or in other financial documents
- Unexplained disappearance of funds or valuable possessions
- Provision of substandard care or bills unpaid despite the availability of adequate financial resources
- Provision of services that are not necessary
- Discovery of an elder’s signature forged for financial transactions or for the titles of the elder’s possessions
- Sudden appearance of previously unin-
volved relatives claiming rights to an elder’s affairs or possessions
• Unexplained sudden transfer of assets to a family member or someone outside the family
• An elder’s report of financial exploitation

Abandonment was defined as the desertion of an elderly person by an individual who had physical custody or otherwise had assumed responsibility for providing care for an elder or by a person with physical custody of an elder.

Signs and symptoms of abandonment include the following:
• Desertion of an elder at a hospital, nursing facility, or other similar institution
• Desertion of an elder at a shopping center or other public location
• An elder’s own report of being abandoned

Neglect was defined as the refusal or failure to fulfill any part of a person’s obligations or duties to an elder. Neglect may also include a refusal or failure by a person who has fiduciary responsibilities to provide care for an elder (eg, failure to pay for necessary home care service or failure on the part of an in-home service provider to provide necessary care). Neglect typically means the refusal or 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.

Signs and symptoms of neglect include the following:
• Dehydration, malnutrition, untreated bedsores, and poor personal hygiene
• Unattended or untreated health problems
• Hazardous or unsafe living conditions (eg, improper wiring, no heat, no running water)
• Unsanitary or unclean living conditions (eg, dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing)
• An elder’s report of being neglected

SELECTED NEAIS FINDINGS

The distribution of the types of new incidents of abuse experienced by elders in 1996 and substantiated by APS follow-up is as follows, including elders experiencing multiple types of abuse: neglect, 48.7%; emotional, 35.4%; financial, 30.2%; physical, 25.6%; abandonment, 3.6%; and sexual, 0.3%.

Nationwide, in 1996 females constituted 57.6% of the US population. For most categories of abuse, females represented most of the NEAIS victims experiencing abuse. The following distribution indicates the proportion of victims who were female for each type of abuse: emotional, 76.3%; physical, 71.4%; financial, 63.0%; neglect, 60.0%; and abandonment, 37.8%.

Approximately 3 of 4 elder abuse and neglect victims suffered from physical frailty, with 47.9% involving elderly persons who were not physically able to care for themselves. Six of 10 elder abuse victims experienced some degree of confusion, and 45% of the total group had some degree of depression.

Male perpetrators constituted 53% of the abusers in total. The distribution of male perpetrators among the different types of abuse is as follows: abandonment, 83.4%; physical, 62.6%; emotional, 60.1%; financial, 59.0%; and neglect 47.6%.

The majority of elder abuse perpetrators were younger than 60 years (65.8%). The largest category of perpetrators (47.3%) with regard to their relationship with the abused elder was the adult children of the victims. The following distribution shows the proportion of victims abused by their adult children, by type of abuse: abandonment, 79.5%; financial, 60.4%; emotional, 53.9%; physical, 48.6%; and neglect 43.2%.

The abused elder’s spouse was the next largest category of perpetrator (19.3%). The following distribution shows the proportion of victims abused by their spouses, by type of abuse: neglect, 30.3%; physical, 23.4%; emotional, 12.6%; abandonment, 6.4%; and financial, 4.9%. Other relatives were the
third most frequent category of perpetrators (8.8%), with grandchildren following closely (8.6%). Many NEAIS sentinels noted that they often encountered situations in which elderly persons did not want incidents reported because the relatives who would be implicated were their only source of support or because they might risk abandonment or reprisals.

**NEAIS IMPLICATIONS**

Elder abuse is more difficult to detect than child abuse, since the social isolation of some elderly persons may increase both the risk of maltreatment itself and the difficulty of identifying that maltreatment. Approximately 25% of elders in the United States live alone, and many others interact primarily with family members and see very few outsiders. Children, in contrast, never live alone and are required by law to attend school from age 5 until 16. Consequently, by kindergarten, children come into contact with at least 1 institution outside the home almost daily during much of the year for most of their childhood.

Although community sentinels appear to be valuable sources of information about abuse and neglect of elders, neither they nor other reporting sources can conclusively account for victims of domestic abuse and neglect who do not leave their homes and who rarely come into contact with others. This leaves the problem of elder abuse one that will continue into the foreseeable future. There is no reason to believe that all elderly applicants for insurance are somehow protected against abuse or have their abuse situations successfully resolved before filing an application for insurance.

Since the NEAIS examined a random sample of the US general population, it may be reasonable to assume that its estimated 1% to 2% incidence rate of elder abuse among those aged 60 years and older may be lower among those elders seeking insurance. This assumption reflects the known difference in impairment prevalence (such as heart disease) among younger insurance applicants and the prevalence of such impairments within the general population. However, even if the incidence of elder abuse among insurance applicants aged 60 and older is <1%, it still exists as a problem; anecdotal evidence shared with this author has revealed that cases of elder abuse are being seen by insurers on a regular basis.

In the NEAIS, bank employees were enlisted as community sentinels to be alert for signs of elder abuse. Although they uncovered a small proportion of the total victims identified (0.4%), the study's authors noted that in the future, employees of financial institutions may be educated and encouraged to detect and report abusive situations. States and communities such as Massachusetts and San Diego, Calif, already have strong bank reporting of financial exploitation of elders. Insurers are in a position similar to those of banks, in that they have privileged access to personal situations and information that may uncover abuse. An insurance application in an abusive situation may involve a deliberate attempt at antiselection, or there may be a justifiable insurance need while the abuse is incidental.

Currently, anecdotal evidence has suggested that insurers keep privately acquired information about elder abuse private. This is consistent with strict privacy requirements demanded of insurers irrespective of any other concerns. It is also apparent that when the presence of elder abuse is revealed, underwriting professionals are advised not to take adverse underwriting action on the basis of the abuse itself but to act only on impairments related to the abuse, if any are present. This approach has its basis in the insurance industry's experience with marital violence. Recent legal cases targeting adverse underwriting actions against battered women established the precedent of underwriting the sequelae of abuse, not the abuse itself.

If the NEAIS authors' suggestions for enlisting financial institutions as community sentinels for reporting elder abuse are accepted by the public, there would need to be a satisfactory resolution of the dilemma pre-
sented by insurers’ previous experience with family violence and, more importantly, the insurance tradition of privacy. The public cannot expect insurers to preserve the privacy of its applicants and yet to make exceptions to this universal practice, even when it would be to the public good. Once an exception is made, there may be no real basis to start denying a greater variety of exceptions for a variety of purposes.

UNDERLYING CAUSES OF ELDER ABUSE

One of the myths of elder abuse is that an "overwhelmed caregiver" is often most responsible for the abuse or neglect of the elder in his or her care. This theory emphasizes that the increased frailty and dependence of an elder on a caregiver cause stress, and then an otherwise responsible and well-meaning individual loses control and becomes abusive. In this view, elder abuse is seen as essentially a natural outgrowth of the aging process that leads to the need for family care.

Although a large number of the elderly are dependent on family members, only a small minority are abused, even when one accounts for the hidden number of undetected victims. Case-control studies that have compared victims with nonvictims matched for health and functional status found that degree of physical and cognitive impairment did not predict subsequent abuse. In these studies, it was found that the victims were distinctly unlike-ly to rely on the abuser for help with their activities for daily living.

These studies and others have found that the abuser was more often dependent on the elders for financial assistance, housing, household repair, cooking, cleaning, and transportation. This has resulted in the observation that elder abusers are not healthy, stable, well-intentioned caregivers but tend to suffer from a variety of mental health, substance abuse, and stress-related problems. All the studies that had sought information on elder abusers had found these individuals to be far more likely than nonabusers to be violent in other contexts, to have been arrested, or to have been hospitalized for psychiatric reasons.

COMMENTS AND SUGGESTIONS

Anecdotal evidence suggests that insurers currently take a highly guarded stance in underwriting cases of elder abuse. Insurers have been put in a public position that to decline or rate an abuse case would "revictimize the victim." The most frequent source of information about elder abuse is the attending physician. The public disclosure by an insurer of any information confidentially shared by an attending physician would greatly inhibit future cooperation by attending physicians with insurers.

Moreover, many agents and brokers have been advised not to intervene as insurance professionals in an abusive situation because of liability concerns. Agents and brokers may disclose to an insurer that an abusive situation may exist, but as with similar instances of discovering medical conditions, they should not presume to provide a diagnosis or intervention. This greatly limits any role that an insurer currently can play as a elder abuse community sentinel.

If the public truly wishes to effectively employ insurers as community sentinels, there will need to be protections allowed insurers that would enable them to act in the public interest. First, the traditional constraints of absolute confidentiality currently observed by insurers would have to be loosened. To what extent this loosening would be appropriate to achieve the positive goal of reporting abuse would have to be discussed, as well as the effect such changes would have on other situations, such as an applicant's proven consumption of illegal drugs or the presence of a reportable infection such as HIV.

Second, insurers must be allowed to perform their role as community sentinels without consequent liability. The lack of such protection would effectively inhibit any disclosure, even if it were permissible to make such a disclosure. Discussion of this new privilege
would need to be conducted, and then the agreed results would need to be enacted within the appropriate regulations and laws. Because insurers in the United States are regulated on a state-by-state basis, the changes needed to enable them to become community sentinels would necessitate changes on the same basis.

At present, there are no reliable follow-up studies that quantify the increased risk of mortality attributable to elder abuse. If such studies were available, there may be far less dispute over the appropriateness of an adverse underwriting action. However, there is no reason to believe that the risk of mortality for an abused elder is the same as or less than that for an elder who is not abused, when all other risk factors are equal. Elders who are subjected to trauma suffer disproportionately high injury-related mortality rates compared with younger adults.3

As previously discussed, anecdotal evidence suggests that the current underwriting of elder abuse may involve adverse actions taken only with regard to abuse sequelae and not the abuse itself. This approach toward underwriting the history of abuse is completely different than the underwriting done for any other type of impairment estimated to increase the risk of mortality. An opportunity to reexamine the premise on which this practice is based may be appropriate during any discussion of using insurers as community sentinels.

There may be some insurers that choose to individually consider each case of elder abuse on its own merits. If there is concern that abuse exists in a case, these insurers may wish to include the definitions, signs, and symptoms of elder abuse as used in the NEAIS for risk selection purposes. Since this set of terms and criteria has already been used acceptably on a national basis, this resource is convenient in its consistency and applicability. The demographic and personal attributes of elderly victims and their abusers may also serve to identify cases more accurately.

Some insurance applications inquire about a recent history of violence. Given the experience of the NEAIS, there is no reason to believe that all elder abuse victims will truthfully report their history of abuse. However, anecdotal evidence does support the reporting of some cases of abuse to the insurer by the applicant, as well as abuse information revealed by the attending physician. Should an insurer wish to inquire further, information on the household environment and members of the household can be evaluated for signs of abuse, using observations made by brokers, agents, paramedicals, and other third-party inspectors. An insurer would need to make a clear decision to support this inquiry and then provide the proper guidance to optimize the sensitivity and specificity of all elder abuse detection criteria. The training materials developed for the NEAIS may be a useful start.

The US Administration on Aging encourages reporting suspicions of elder abuse to the local APS agency.4 If an acceptable means for insurers to become community sentinels is found, then this may be the mode by which insurers convey their reports. The local APS may be contacted by calling directory assistance and requesting the number for the department of social services or aging services. The Administration on Aging also provides the correct telephone number for the local APS with its Eldercare Locator at (800) 677-1116. It is helpful to provide the address and zip code of the elder's residence.

The National Center on Elder Abuse may be a useful resource to life underwriting professionals. Its address is National Center on Elder Abuse, 1225 I St NW, Suite 725, Washington, DC 20005; telephone (202) 898-2586; fax (202) 898-2583; http://www.gwjapan.com/NCEA.

Insurers may wish to include material about elder abuse in their customer education and community awareness publications. Proactive efforts such as these may be appreciated by the community as well as by current and prospective customers.
REFERENCES


