TRABALHO COM VISTA À ATRIBUIÇÃO DO GRAU DE MESTRE NO ÂMBITO DO CICLO DE ESTUDOS DO MESTRADO INTEGRADO EM MEDICINA

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ELDER ABUSE - A REVIEW

ARTIGO DE REVISÃO

ÁREA CIENTÍFICA DE MEDICINA LEGAL

TRABALHO REALIZADO SOB ORIENTAÇÃO DO

PROFESSOR DOUTOR DUARTE NUNO VIEIRA

FEVEREIRO DE 2014

This work was based on two book chapters

which are to be published during 2014:

Santos CL, Vieira DN. *Abuso de idosos*.
In: Veríssimo MT (Coord.). Geriatria - Saber e Praticar. Lidel.

Santos CL, Vieira DN. *Abuso de idosos: conceitos gerais, aspetos médicos e legais*.
In: Almeida F, Paulino M (Coord.). Psicologia & Temas Forenses: Perspetivas Atuais*. Pactor.

** This book's title may be subjected to changes by the publisher.*

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Abstract

Elder abuse is not a recent phenomenon. However, only in the second half of the XX century it has been acknowledged by the scientific community and the society as a whole. This work aims at compiling some of the scientific knowledge acquired over the years, with reference to the most relevant historical aspects, evolution of concepts, definition of abuse topologies, epidemiology and theoretical models. In addition, it addresses the relevance of the shift in paradigm towards viewing violence as a matter of public health, emphasizing the roles that professionals (namely health related) may assume in the battle against elder abuse. Finally, the forensic aspects of dealing with these cases in the context of a medico legal evaluation and the Portuguese judicial system are discussed.

Keywords

Elder abuse; mistreatment; violence; legislation

1. Introduction

Over the past decades the world has seen significant demographic changes, more accentuated in western societies, due to the growth of the elderly population.

The World Health Organization (WHO)[1] estimates that the world population of individuals aged 60 or above, between 2000 and 2050, will double (11% to 22%), with an increase of the absolute number of individuals from 605 million to two billion. This Organization also believes that some countries, namely Brazil and China will take less than 25 years to double the population aged 65 years old or above, a process that took other countries, such as France, more than a hundred years. The underlying factors that promote these changes are the increase in life expectancy, attributed to the success of health policies and socioeconomic growth, and the decline of fertility rates.

This scenario prompts for the need to elaborate public policies specifically directed towards elder individuals, namely in the field of abuse prevention and management.

2. Historical background

The year of 1975 is traditionally acknowledged as pivotal in the awareness for elder abuse by the medical society, after Baker[2] and Burston[3] expressed, in *Modern Geriatrics* and *British Journal of Medicine*, respectively, their concern about what they designated *granny battering*.

Nonetheless, it should be highlighted that since the beginning of the 1950's the Unites Stated of America (USA) developed financial incentives for the states to provide protection services, however with questionable costs and efficiency.[4]

In the 1970's, due to reports of elder abuse and neglect in institutions, in-depth analysis was undertaken with the supervision of the United States Senate Special Committee on Aging.[5]

In 1981, a Commission of the US House of Representatives[6] stated that elder abuse "was far from being and isolated and localized problem (…) but nationwide, with a frequency that few imagined and that abuse by relatives and caregivers were occurring in a rate only slightly less than child abuse".

In 1988, a pioneer study by Pillemer and Finkelhor,[7] based on a sample of North-American population, revealed an abuse prevalence rate of 32 per 1000 adults and found that physical abuse, verbal and neglect were the most common types of maltreatment.

In 1998, the National Elder Abuse Incidence Study (NEAIS)[8] coordinated by the National Center on Elder Abuse (NCEA) revealed that between 210.900 and

688.948 persons aged 60 or above may have been victims of domestic abuse or neglect during 1996.

The US has been the nation that probably has produced more laws, rules and regulations on this issue. In a federal level, for instance, several acts were approved, namely, the *Older American Act, Elder Justice Act, Public Health Service Act, Social Security Act* and *Violence Against Women Act* that allowed, among other aspects, to insure a federal response thought programs of social service, nutritional, training and other services, and funding for their implementation.[9]

As for the United Kingdom (UK), it has been considered slow to respond to the challenge, with persisting resistance to the idea that such a problem could exist.[10] McAlpine[10] states that a major catalyst for recognizing this issue was the multidisciplinary British Geriatric Society Conference *Abuse of Elderly People: an Unnecessary and Preventable Problem*, held in 1989. As a matter of fact, the following year, the British Medical Journal published the first paper, concerning the abuse of older people by their caregivers. In 1993, the UK Foundation *Action on Elder Abuse* was formed and later developed a definition of abuse that was adopted by the WHO.

The creation of the International Network for Prevention of Elder Abuse (INPEA), in 1997, supported by the United Nations (UN) and WHO, with representation from more and less developed countries throughout the world, indicates increasing international concern about elder abuse.[11]

Although most published research comes from countries such as US, Canada, UK or other European countries, the situation has been changing, and, in 2001, the WHO and INPEA held focus groups in several countries including Kenya, Lebanon, Argentina, India and Brazil, aiming for a more broader research and international cooperation.[11,12]

In the European Union (EU), elder abuse seems to have become an ongoing concern in the latest years as countries face progressively inverted population pyramids. Georgantzi[13] stated that elder population (65 years or above) represented 17% of the total EU population in 2010 and according to the latest projections, the number should double before 2060. Meanwhile, it's estimated that a third will suffer from dementia and much more may be exposed to social isolation and poverty.

In this context, the EU has been funding several projects, such as EUSTaCEA, WeDO (Wellbeing and Dignity of Older People), EuROPEAN (The European Reference Framework Online for the Prevention of Elder Abuse), ABUEL (Elder Abuse), MILCEA (Monitoring in Long term care Pilot project on elder abuse), Interlinks, ANCIEN (Assessing Needs of Care in European Nations).

In Portugal, there are also studies concerning this subject, with particular relevance for ABUEL[14] and AVOW[15] as they were integrated in an international framework. Since 2011, a nationwide project "Ageing and Violence", coordinated by the Portuguese National Health Institute, partnering with other Institutions, including the Portuguese National Institute of Legal Medicine, aims to develop a multidimensional perception of the Portuguese reality.

Since 2006, following an INPEA and WHO's initiative, the 15th of July was established as the World Elder Abuse Awareness Day, hoping to promote a deeper understanding over the social, demographic, cultural and economic factors that potentiate this problem and recognizing it as a matter of public health and human rights.

3. Conceptualization of elder abuse

A primordial question when discussing elder abuse is: from which age is an individual considered old?

In this regard, some studies consider 65 years old as the cut-off age[16], probably due to the legal retirement age previously in use in many western countries, while others established 60 years[17], namely the UN. Furthermore, as Gorman points out the definition of old age in underdeveloped countries is even more difficult "as chronological time has little or no importance in the meaning of old age".[18] This author states that "socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible". However, for practical reasons, 50 years was the cut-off age in the MDS (Minimum Data Set) project studying sub-Saharan Africa.[19]

What about violence, abuse and mistreatment, can they be considered synonyms? For some authors these terms seem to have different meanings, for instance, abuse may imply some unequal power relation between the parties. However, in the World Report of Health and Violence[20] and respective translations, they seem to be used interchangeably. This apparent lack of consensus allows for their use as synonyms.

Furthermore, some authors, such as O'Malley[21], advocated the need to replace the terms abuse and neglect altogether by the concept of inability to fulfill the need of the elder adult, decreasing the degree of criminalization and stigmatization in the context of caregiver stress theory.

In 1985, the Elder Abuse Prevention, Identification and Treatment Act[22], defined abuse as the "willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish, or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness".

In 2002, the WHO Declaration of Toronto[23] stated elder abuse as a "single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person".

At least 33 types of abusive conducts were identified in several studies[24]. However, it is possible to group them into 5 main types, according to the classification system currently in use by the WHO: physical, financial, psychological or emotional, neglect and sexual abuse.

Emotional/Psychological	Causing suffering or anguish through verbal threats, social isolation or humiliation.
Financial	Unauthorized or unlawful use of financial resources (e.g. theft, cash or propriety transfer without knowledge by the elder)
Neglect	Inability or denying providing adequate care.
Physical	Inflicting pain or physical harm.
Sexual	Non-consensual sexual behavior, including dialogs with suggestive content.

Table 1 - Types of elder abuse considered by the WHO. [20,25]

Institutional abuse, elder intimate partner abuse or other types of abuse referred by the literature are merely particular contexts where any of the aforementioned types of abuse may occur, in isolation or combination.

Theoretical models aiming to capture the underlying motives for abuse as the interplay between them have been developed, much of them derived from models for child abuse and domestic violence[25].

Bidirectional violence	Caregiver and the victim propitiate mutual aggression.
Exchange theory	Reciprocity and dependence between the abused and the perpetrator. It suggests that abuse can occur within a framework of tactics and responses in family life.
Feminist theory	Based on domestic violence models, highlighting the imbalance of power within relationships and how men use violence as a way to demonstrate power.
Intergenerational transmission	Theory states that an adult's behavior relates to previous learned behavior as a child, thus reverting to the same pattern in adulthood.
Intra-individual dynamics (psychopathology)	The abusive behavior is related to psychopathologies (schizophrenia or psychosis).
Situational theory	An overburdened and stressed caregiver creates an environment for abuse.
Political economic theories	Criticizing the emphasis on individualistic theories, it claims that structural forces and the marginalization of elders within society have created conditions that lead to conflict and violence.

Table 2 - Theoretical models of elder abuse.[11,25,35]

These models emphasize particular aspects of elder abuse which leads to misinterpretation of real life contexts. Thus, the ecological model interprets violence as the complex interplay between individual characteristic, community and interpersonal relations, allowing for abuse to be discussed as a broader social issue. [20,25]

4. Elder abuse: a public health issue

Dahlberg & Mercy[26] stated that "as public health efforts to understand and prevent violence gained momentum in the United States, they garnered attention abroad."

An important step was taken in 1996 when the World Health Assembly adopted Resolution WHA49.25, which declared violence "a leading worldwide public health problem.". [27]

The publication of the World Report on Violence and Health[20], in 2002, further consubstantiated violence as a serious public health issue, acknowledging the negative impacts on the victims' health and also the existence of risk factors amenable to monitoring and control. As a matter of fact, it is recognized the cognitive and psychological negative effects of abuse, with increased stress levels, sense of powerlessness and increased morbidities and premature mortality rates.[28]

4.1. Epidemiology

From an epidemiological perspective, one of the fundamental problems has been to determine of true incidence and prevalence rates.[24,34,44] In spite of these difficulties, it was soon realized that, contrary to popular belief, most abuses occurred in a family environment rather than in institutional settings, which is comprehensible even from a statistical point of view, as 95% of elders live alone or with their spouses, sons or other relatives and not in an institution.[29] Thus, family members or paid caregivers working at the elder's home are more likely to become abusers. Some authors speculate that the lower prevalence of abuse by institutional caregivers, in relation to family, may be justified by less contact hours.[30]

Espindola and Blay[31] performed a systematical review of global prevalence violence rates towards older people, having found estimates ranging from 0.8% to 16,6%, a variation that could result from several factors, namely, different conceptualizations, measurement scales, types of relationships or age group considered.

Cooper et al[30] analyzed studies of prevalence where abuse has been reported by elders, relatives, professional caregivers or investigated using objective measures, for a total of 49 studies. Only 7 used validity and reliability measures. There were great oscillations of prevalence rates (3.2–27.5%), reasoned by the authors as conveying the

real abuse rate variance across cultures or different methods to define and measure abuse.

The rates for each main type of abuse are also variable. For instance, Espindola and Blay[31], found the following distribution: physical abuse (1,2-18%), financial abuse (1,4-4,3%), psychological abuse (29,6 - 49%) and neglect (0,4-24,6%).

Although physical abuse is the most frequently reported form of abuse,[32] several studies show that emotional abuse is high, undetected and difficult to identify, measure and differentiate from the normal dynamic in some interfamilial relationships.[33]

The literature identifies several risk factors, that may be synthesized as those related to the victim, the abuse and the context.

The **victim** is traditionally considered as being female and older than 75 years old.[20,24] However, some authors have suggested that the magnitude of injuries in women could justify an increased number of complaints and that there are no real gender-related differences.[34] Male individuals could actually be more frequently victims of abuse, since they are more likely to live with other people, which is itself a risk factor. Elder dependency, excess loyalty, transgerational conflict history, internalization of guilt have been considered as a risk factor for abuse.[24] As for alcohol consumption, some studies imply it is a risk factor[24], while others state that neither drinking, religion, education nor economical background correlate to violence.[34] Cognitive deficit of the victim may lead to disruptive behavior and aggression to the caregiver[20]. Theories relating disability and dependence, although popular, have yet to demonstrate a direct correlation between abuse, health problems and caregiver dependency.[35] Finally, some authors have considered that perhaps the most significant risk factor for abuse is a previous history of victimization. [24]

The **abusers** are more usually relatives, in particular the sons of the victims, followed by their spouses when they are the caregivers.[24] Other risk factors are alcohol consumption, drug abuse, caregiver inexperience, dependency of the caregiver from the victim, history of abuse as a child, hypercritical personality and unrealistic expectation.[24,34]

Ramsey-Klawsnik[36] proposed five types of abusers: *overwhelmed offenders, impaired offenders, narcissistic offenders, domineering or bullying offenders and sadistic offenders*.

Context evaluation is an important aspect of risk assesment.[35] For instance, some case-control studies have shown that socially isolated elders are potential victims, while those engaging in regular social interactions with other people are less likely to be abused since there is a higher probability for an early detection of abuse. Living arrangements are also relevant as there is an increased risk of violence when victim and abuser share the same space, probably due to cumulative effect of tensions and difficulty in resolving conflicts.[35,43]

In summary, abuse results from the complex interplay of several risk factors, whose specific contribution is not consensually defined amongst authors.

4.2. Stages of prevention in Public Health

Bernal and Gutierrez[37] stated that "by considering the natural history of abuse as a disease, beginning by an ideal situation of healthy, without risk factors, one can proceed to another with risk but without abuse that, later, evolved to occult mistreatment or the detection of manifest abuse, sometimes, chronic". These authors are describing main levels of prevention: primary, secondary and tertiary.

Primary prevention acts upon the causes and risk factors to prevent the occurrence of violence and applies strategies that target mainly four groups: society, professionals, informal caregivers (family) and elderly people.

The intervention at a society level includes public information regarding violence, definition of programs that promote active aging and also providing proper alternatives to family care giving (such as nursing homes).

Programs directed towards professionals that may interact with potential victims of violence, providing knowledge and awareness for risk factors as well as signs/indicators of abuse are also relevant.

Acting at the informal caregiver level, programs aim to find ways to reduce caregiver stress, including applying psycho-educational strategies, teaching the best ways to manage problematic behavior by elder individuals or how to provide specific care related to particular health problems.

Lastly, it is import to increase elder individuals' awareness for the different and sometimes subtle ways abuse may manifest itself and that there are (should be) adequate reference support systems.

Secondary prevention occurs in a context of hidden ongoing violence and thus, the aim is to promote early diagnosis and intervention, avoid reoccurrences and more serious consequences.

In this regard Perel-Levin[25] pointed out that there is a continuing debate whether there should be a systematic screening at primary care level. There are those who argue that evidence is insufficient to allow an effective cost-benefit assessment in cases of familial or conjugal violence and it shouldn’t be implemented.[25] On the other hand, other authors, such as Bernal e Gutiérrez,[37] stated that it is convenient to integrate

the analysis of risk factors for mistreatment as ancillary in the overall evaluation of an individual's health status.

Nonetheless, even assuming a pro-screening position, one must recognize the significant obstacles to overcome in order to implement it, namely, determination of the tools that are most appropriate to screen and to promote uniformity in the application; adequate training of the professionals to skillfully apply them; good doctor-patient confidence; good communication between health professionals that take care of the victim and intervention capacity – which ultimately will determine the usefulness of the screening.[25]

Nowadays early diagnosis is perhaps only performed in anecdotal cases in a routine medical consultation and this occurs due to various difficulties, some related to health professionals and others to the victim or the abuser.

Bernal and Gutiérrez[37] emphasized that the victim tends to minimize abuse due to shame, fear of punishment, isolation or threat to be committed to an institution, self-guilt, not viewing themselves as victims or caregiver dependency. In addition, the abuser may attempt to isolate the victim to avoid reporting of the abuse situation, fear to assume failure or possible legal consequences.

Health professional should be aware of the most important signs/indicators and the best course of action thereafter, aspects that will be further developed later in this text.

The **third level of prevention** occurs when an abuse situation is explicit and the damages are undeniable. Thus, the intervention includes the creation of programs to improve the quality of life of the victims, breaking the cycle of violence and providing the means to prevent new episodes of abuse.

Bernal and Gutierrez[37] also mention a fourth level of intervention – the so called **primordial prevention**. It focuses on the elimination of patterns of social, economic and cultural life that are linked to a high risk of violence and selection of those that promote wellbeing. As a matter of fact, it is generally acknowledged that unemployment and economic crisis are related to an increase of violence and that the norms and values of the society influence the way this phenomenon is socially perceived.

Over this matter, Bernal e Gutierrez[37] pointed out that some of the key elements in primordial intervention are: valorization of the image and status of the elderly individual in our societies, as well as elimination of negative stereotypes towards them - fight against *idaism*; diffusion of knowledge about this stage of life to the professionals that deal with this population, as well as support to the scientific investigation; development of structures to support elder population in active aging and to intervene in the minimization of vulnerability factors that promote violence.

4.3. The role of the health professionals

Since violence has been considered a Public Health problem, the spotlight has turned to health professionals as key elements to early diagnosis and orientation of the victims.

As Kahan and Paris cited by Perez-Carceles[38] mentioned, health professionals may be the only persons in a victim's life able to recognize the situation and provide help. Nevertheless, physicians rarely report abuse cases, although they are in an ideal position to do so.[39] The problem may rely in the fact that health professionals are not specifically trained to detect and manage cases of suspected abuse.[24] Due to the complexity of factors, especially when the abuser is the caregiver, a certain amount of

sensitivity to identify the signs of violence and how to properly intervene is required. Furthermore, general practitioners appear to be particularly well positioned to identify these cases,[43] however they do not feel adequately prepared, probably due to the fact that interpersonal violence is not yet part of medical education.

Thus, the main challenges for greater health professional involvement in this mission are: lack of knowledge; insecurity in case management; unknowing the proper course of action; denial; suspicious of reports relating those to senility, dementia, lying or exaggeration; lack of adequate resources.[40]

Education based on evidence and proper training are essential for family physicians to acquire skills in identifying and managing abuse cases.[41]

Day[42] emphasizes that nursing staff could also assume a role in this matter, namely in the Emergency Room (ER), although recognizes that the crucial factor to determine the outcome of the patient is the quality of the interface between community and the ER health care.

In spite of the focus on health professionals, naturally related to the significant role they may play in preventing, diagnosing and early intervention, no single person or profession should be completely responsible for managing these cases, but instead responsibility should fall to a multidisciplinary team with health professionals, social services and law related professions that, as a group, aim do accomplish a set of well defined goals.[24]

In pragmatic terms it is relevant to define guidelines on how to correctly approach cases of elder abuse, a subject of careful thought by some authors.[32,37,40] There is some consensus regarding the need to form multidisciplinary teams to increase acting power and to share responsibilities. It should also be highlighted that the ability to intervene is naturally limited to the national and local resources to provide support to

the victims and to the (in) existence of clear defined action plans in the community or workplace.

Abuse types	Signs/Indicators
Emotional/ Psychological	Depressive symptoms, feelings of despair and helplessness. Apathy, lack of appetite, sleep disorder, fear, anxiety, shame, unexplainable apathy, avoiding contact with family and friends, ambivalence of feeling toward the aggressor.
Finance	Lacking belongings or properties; absence of documentation over financial operations; judicial notification though there are financial resources; excessive interest by other people over the financials of the elder; unusual or unexplainable financial transactions; sudden changes in the will; fear or concern related to money.
Neglect	Lack of proper hygiene, malnutrition; teeth lacking condition; inadequate clothing; pressure ulcers, non cared for or in unusual locations; lack of glasses, canes or walkabouts; medical problems not properly followed or treated by health services; abandonment of old people in hospital.
Physical	Skin lesions (excoriation, ecchymoses, lacerations and burnings) suspicious due to quantity, location or diversity. Figurative lesions suggestive of use of ropes or other objects. Springs, dislocation, fractures, discrete areas of alopecia, absence of teeth. Signs of physical restraint or increased loss of muscle. Signs of over or submedication.
Sexual	Lesions in the anogenital area; signs of human bites; presence of unexplainable sexual transmissible disease..

Table 3 – Signs/indicators of abuse for each of the main types of abuse.[4,11,25,34,44]

Assuming the perspective of a health professional (e.g. a general practitioner) that suspects an elder patient is a potential victim of abuse and also recognizes the importance of acting to confirm or deter that hypothesis, it should be aware that the most important tool is the interview. Of course, this interview entails some precautions,[11] such as assuring privacy (the potential abuser should not be present, as it is likely to inhibit disclosure), establishing a doctor-patient trust relationship and allocating the necessary time (which can be a crucial factor, as it is necessary to give time for the victim to reply and gain "courage" to disclose). During the interview care must be taken in maintaining a simple and clear dialog, with phrasing adjusted for the victim's education background. The best approach should allow for an initial free-style type of conversation, then proceeding to more specific and directed questions (Table 4). This strategy aims to decrease the overall feeling of being subjected to an enquiry and,

simultaneously, conveying a nonverbal message of true interest in what the potential victim has to say. Unfortunately, it must be recognized that current pressure on health professionals performance, sometimes limited solely to a crude evaluation based on numbers, tends to impose time constraints and decrease mental disposition for those cases that require more attention to be properly dealt with.

Type of abuse	Questions
Physical	Are you afraid of anyone at home? Have you been struck, slapped, or kicked? Have you been tied down or locked in a room?
Emotional/ Psychological	Do you ever feel alone? Have you been threatened with punishment, deprivation, or institutionalization? Have you received "the silent treatment?" Have you been force-fed? Do you receive routine news or information? What happens when you and your caregiver disagree?
Sexual	Has anyone touched you without permission?
Financial	Is money stolen from you or used inappropriately? Have you been forced to sign a power of attorney, a will, or another document against your wishes? Have you been forced to make purchases against your wishes? Does your caregiver depend on you for shelter or financial support?
Neglect	Do you lack aids such as eyeglasses, hearing aids, or false teeth? Have you been left alone for long periods? Is your home safe? Has anyone failed to help you care for yourself when you needed assistance?

Table 4 – Screening questions for each type of abuse as indicated by Kleinschmidt.[34]

Care must be taken to avoid any verbal and non verbal cues that may be interpreted by the victims as accusatory (which could occur in cases of elders with more difficult personalities), nor accuse or confront the aggressor. It must be remembered that when the abuser is the caregiver, he could be burned out, which tends to happen when providing care for many years.[24,34]

Building up trust is an essential factor to improve success in obtaining disclosure. Sometimes, it may be required to perform many interviews or even resort to other professionals to maximize the odds of disclosure.

In order to make a more objective analysis, there are several risk scales that may be used, according to their limitations and applying criteria, namely, Hwalek-Sengstock Elder Abuse Screening Test(H-S/EAST; Neale, Hwalek et al, 1991), The Brief Abuse Screen for the Elderly (BASE; Reis and Nahmiah, 1998), Caregiver Abuse Screen (CASE; Reis and Nahmiah, 1995), Indicator of Elder Abuse (IOA; Reis and Nahmiah, 1998), Elder Abuse Intrument (EAI; Fulmer, 2003) e o Elder Abuse Suspicion Index (EASI; Yaffe, Wolfson et al, 2008).

If the likelihood of violence is assessed as low, it is advised to regularly monitor the situation. On the contrary, if the probability of abuse is considered high and the victim seems to be in immediate danger or, although not in immediate danger, but not cognitively competent, it is fundamental to delineate an action plan, that may include internment or reporting the case to competent authorities (social security services and/or law enforcement).

In the case of a cognitively competent victim not in immediate danger, information concerning the rights and mechanisms of protection should be provided as well as, with proper consent, orientated to (preferably) a multidisciplinary team to provide a more comprehensive evaluation of the case.

Once more, it is acknowledged the practical obstacles that health professionals are likely to face in their daily practice, as health establishments are usually not logistically prepared for this type of approach. Health system managers, namely at a national scale, must be aware of the importance to adopt measures in this context.

A final word of caution, however, for the dangers of succumbing to the natural impetus of wanting to promptly help the victim without further considerations. As Lachs & Pillemer[43] pointed out, the intervention should be always planned with two concerns in mind: preservation of autonomy and promotion of safety of the elderly.

Although these mainstays of intervention may be, sometimes, in confrontation with each other, their proper equilibrium is the key to successful management of these cases.

5. Forensic aspects of elder abuse

The Portuguese Justice system is the ultimate platform to assist in the defense of citizens' rights, which may be accessed through orientation by non-governmental organizations (such as the Portuguese Association to Support Victims) or by a complaint filed by the victim or third parties (in the case of public crimes) at entities like the Public Ministry (MP), Judiciary Police (PJ), forces of authority (PSP or GNR) or the Portuguese National Institute of Legal Medicine and Forensic Sciences (INMLCF, IP).

5.1 The role of Forensic Medicine

The professionals working at the INMLCF, IP intervene in the forensic evaluation of the victim and the assessment of the consequences of the abuse, usually in relation of investigations of crimes against physical integrity or sexual liberty.

In order to fulfill the objectives of the investigation, a methodical examination is performed, which is adapted to the circumstances of the case and usually includes the assessment of socio-familiar background (previous history of abuse), identification of risk factors, observation and description of the lesions/sequelae, collection and preservation of biological evidence (for instance, in cases of sexual aggression), orientation of the victim and, finally, writing of the forensic report.

A comprehensive and careful analysis of the findings is required. The expert should be alert for incongruous explanations given by the caregiver (in cases of familial violence) and age-related diseases that may mimic mistreatment.

Interpretation of wound location is of particular relevance, as trauma to areas not commonly injured during daily activities or secondary to accidental trauma should cause suspicion. Other relevant criteria to consider when evaluating injuries include certain wound patterns (areas of discrete alopecia; signs of physical constraints in wrists, abdomen or ankles; patterned burns), multiplicity of lesions, various ecchymosis with different discoloration suggesting chronic abuse.[44]

As for age-related aspects that may mimic mistreatment Collins[44] described five main areas of *confusion* when delineating organic disease and abuse: skin findings, bleeding, fractures, malnutrition, and anogenital findings.

The medical expert must decide, according to specificities of each case, the best course of action and, succinctly:

1. If the victim needs medical treatment should be sent to an health establishment for further observation.
2. If needed, ancillary exams may be requested as needed, for instance, imagiology, toxicology, neurology, psychiatry or others.
3. The victim may be oriented to the Social Services professionals working at the Delegations of the INMLCF. They act as a link to other entities that may assist in the follow up of victims of abuse (Social Security Services or victims' protection association). Furthermore, usually a more detailed social assessment is performed and this information is reported to the authorities requesting the exams.
4. Sometimes, more than one observation is needed and the victim is rescheduled for follow up.

Regrettably, sometimes, abuse may manifest itself in the most severe form – the mortal abuse. In this case, the Public Ministry orders a medico-legal autopsy, in which a complete study of the corpse is performed to collect and preserve all evidence that combined with other data collected by other entities (namely, forces of authority) allows a full understanding of the case and the just punition of the culprit(s).

Legal Medicine may, in this setting, assume a relevant role as the link between the elder victim of abuse and the court, allowing through the expert evidence produced, a holistic comprehension of the case and the consequences of mistreatment and, in this way, contribute to assist the Magistrate to consubstantiate the final sentence.

5.2. Elder abuse and the Portuguese Law

The Constitution of the Portuguese Republic[45] is the law of laws, in which the fundamental principles of the democratic regime are consigned, namely, promotion of human dignity, popular will, construction of a free, just and caring society (article 1). All other laws of the republic should abide by these principles.

Other important principles are expressed in the ensuing articles such as the universality of rights (article 12), right to equality (article 13), right to personal integrity (article 25), right to liberty and security (article 27), right to health (article 64), habitation (article 65) and family (article 67).

A special attention for an article dedicated solely to the Third Age (article 72), which states that elder individuals have the right, among other things, to economic security, housing, personal autonomy and enroll in activities to decrease social isolation.

The Portuguese Civil Code[46] is another relevant legal document as establishes a set of norms that regulate the juridical relations of private sphere, namely the rights of personality, juridical capacity and alimony. Of significant relevance are interdiction and

inabilitation (article 138 and following) considering they are legal means to transfer the power of decision to the tutor or the curator and necessarily entail a total or partial loss of autonomy, respectively. Thus, the court's decision to apply these measures should be justified upon a rigorous physical and psychiatric assessment.

The Portuguese Penal Code[47] comprehends a set of criminal topologies that characterize illicit behaviors and their respective penalties.

Payne[48] mentions that elder abuse may be conceptualized as a violation of the criminal law and grouped the North-American federal and state laws as follows:

1) Laws penalizing offenders for crimes against older individuals. *These are criminal statutes that call for increased penalties for crimes against persons over a certain age (the so called penalty enhancement laws)*;
2) Laws specific for older persons. *Criminal laws regarding the treatment of older persons and that specifically apply to this population. Failure to provide care to an elder or specific laws covering crimes occurring in nursing homes or other long-term care settings are examples*.
3) General criminal statutes. *Applied when States do not have specific laws related to elder abuse*.

The Portuguese Criminal Law doesn't specifically criminalize misconducts against elder individuals, though some articles state that the sentence should take into account age, implying that crimes perpetrated against younger or older individuals should be aggravated.

The following table contains a non-exhaustive selection of crimes defined in the Portuguese Criminal Law and attempts, as much as possible, to correlate them with specific forms of abuse:

Type of Abuse	Article	Criminal behavior	Prison sentence*
Neglect	148º	Offense to physical integrity by neglect	Up to 1 year [a)]
Physical	143º	Simple offense to physical integrity	Up to 3 years [a)]
	144º	Aggravated offense to physical integrity	2 a 10 years
	145º	Qualified offense to physical integrity	Up to 12 years
Sexual	163º	Sexual coercion	1 a 8 years or Up to 2 years [c)]
	164º	Violation	3 a 10 (maximum) or Up to 3 years [c)]
	165º	Sexual abuse of person incapable of resistance	6 months a 10 years
	170º	Sexual harassment	1 year [a)]
Emotional	180º	Defamation	6 months [a)]
	181º	Libel	Up to 3 months [a)]
Financial	203º	Theft	Up to 3 years[b)]
	204º	Qualified theft	Up to 8 years
	205º	Abuse of trust	Up to 8 years
	215º	Property theft	Up to 2 years [a)]
	217º	Swindle	Up to 3 years [a)]
	218º	Qualified swindle	Up to 8 years
Miscellaneous	152º	Domestic Violence	Up to 10 years
	152º-A	Mistreatment	Up to 10 years
	153º	Threat	Up to 1 years [a)]
	154º	Coercion	Up to 3 years [a)]
	158º	Sequestration	Up to 15 years

** Minimal and maximal imprisonment penalty defined in the article.*
[a)] Or a fine.
[b)] Or a more serious penalty if defined by other laws.
[c)] In case the conduct is perpetrated by abuse of authority in the context of a family relationship, by the tutor or curator or hierarchic dependency, without resort to violence, serious threat or by rendering the victim unconscious or unable to resist.

Table 5. Correlation between articles selected from the Portuguese Penal Law and type of abuse.

A particular attention to the crime of Domestic Violence (article 152) as it encompasses several types of abuse (physical, emotional, sexual) and multiple abusers (spouse, ex-spouse, progenitor for 1st degree descendant or co-inhabitant of helpless person due to age). Furthermore, it is considered a public offense which means that the

Public Ministry is obliged to investigate the case avoiding the once frequent withdrawal of the complaints by the abused due to pressure exerted by the aggressor.

Considering the estimated incidence of domestic elder abuse, it is understandable that the criminal system should provide solutions aside from imprisonment. In this regard, the Portuguese Penal Code previews the substitution or suspension of such sentences, based on some criteria, allowing the court to impose on the convict the abidance to a set of conduct rules, amenable to monitoring and aimed toward reintegration. The court may rule that the abuser should attend special programs, perform certain activities or comply with predetermined obligations. It may even, after the convict's informed consent, decide that it should be subjected to medical treatment, for instance, to avoid alcohol or abuse drugs consumption.

In summary, although the Portuguese normative and legal frameworks don't include crimes specific for elder abuse, it concedes several juridical solutions to defend elder citizens' victims of abuse.

6. Conclusions

Elder abuse is a relevant problem especially in modern societies whose actual and projected demographic changes provide the opportunity for increased violence risk.

Although it was a known issue, at least in the USA, since the second half of the XIX century, only in the last quarter has gained public awareness, namely from professionals from different sectors of societies. Various associations and networks have been founded and projects were funded to better tackle this issue.

A pivotal paradigmatic change has been the declaration of violence as a matter of public health by the WHO, shifting the focus of this issue to the realm of health related sciences.

In this context the strategies of intervention are delineated at primary, secondary, tertiary and primordial levels of prevention. Although several types of abusive conducts have been identified, the WHO has been using a system of five main types of violence: emotional/psychological, physical, sexual, neglect and financial. Models explaining elder abuse are mostly derived from those of domestic violence and child abuse. Nowadays, the ecological model is regarded as the one that better congregates the complex interplay of risk factors.

Health professionals have been regarded as occupying a strategic position and having the knowledge for an early detection and intervention of abuse. However, due to several reasons, some related to the professionals themselves, others to aspects of the victim or the abuser, there have been difficulties to accomplish that desiderate.

Furthermore, there has been an ongoing debate whether systematic screening programs should be carried out and how they should be designed to achieve the best results, considering all different potential challenges.

Nonetheless, when health professionals (e.g. general practitioner) suspect an elder is victim of abuse they should (even on ethical grounds, if not others) pursue further investigation. The best tool at his/her disposal is the interview, which should be performed being aware of certain particularities.

Although the responsibility seems to rest solely upon health professionals, as many authors have pointed out, no single professional should be responsible for managing these cases and the best approach seems to be multidisciplinary. However, it should be recognized, once again, there are many practical limitations since the system (at least in Portugal and for the time being), doesn't provide enough support for this approach.

The ultimate platform for defending the elder individuals' rights is the Judicial System and it is within its framework that the professionals of the INMLCF apply their knowledge, providing expert evidence for the courts to better assess the consequences of the abuse and consubstantiate the cases, mostly those regarding some form of physical/sexual abuse. The investigation by other judicial forces are naturally needed to properly investigate these cases.

Although several steps have been already taken, due to the current international conjuncture, there is a potential risk of regression of the milestones already achieved.

In conclusion, now it is time for more action! As a society we must insure that elders are truly seen as any other citizen, entitled to their own rights, liberties and guarantees.

7. References

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