Geriatric Health – Elder Abuse, Neglect, Ageism and Social Isolation
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Elder abuse, neglect, loneliness and the difficulties encountered with ageist attitudes are one of the biggest challenges faced by the elderly in most societies worldwide. The World Health Organization in its World Report on Health and Aging (2015) addresses many of the issues facing individuals as well as governments in dealing with an ever increasingly aging population.

During the 20th century, the number of persons in the United States over age 65 has tripled and is expected to more than double within the next 25 years. As a consequence, the elderly, who comprised only 1 in every 25 Americans (3.1 million) in 1900, made up 1 in 8 (33.2 million) in 1994. According to the Census Bureau's projections, the number of elderly Americans will more than double between now and the year 2050 to 80 million with most of this growth having occurred between 2010 and 2030. During this period, the number of elderly will grow by an average of 2.8 percent annually with the ethnic diversity of the aging population remaining similar to what it currently is.

The "oldest old", those aged 85 and over are the most rapidly growing elderly age group. Between 1960 and 1994, their numbers rose 274 percent. In contrast, the elderly population in general rose 100 percent and the entire U.S. population grew only 45 percent. The oldest old numbered 3 million in 1994, making them 10 percent of the elderly and just over 1 percent of the total population. Due to the arrival of the baby boom generation, it is expected the oldest old will number 19 million by 2050. That would make them 24 percent of elderly Americans and 5 percent of all Americans. [1]

Adding to this increase; during this period total mortality rates have decreased approximately 19% with women living longer than men and African Americans. [2]

The present medical system is ill prepared to treat the ever increasing elderly population due in part to the compartmentalization of care that allopathic medicine has become as well as a lack of understanding of the aging process. Additionally, physicians generally treat older patients differently as they are less comprehensive and aggressive when faced with the complexity of an elderly persons many comorbid diseases. [2] With the exception of Geriatricians, a few Family Practice physicians and Naturopathic physicians, most physicians have not received the necessary training in order to treat an increasingly complex and aging population.

Additionally, the present allopathic system actually contributes to increased elder morbidity through the use of drug induced poly pharmacy. While the elderly constitute about 12% of the population, they consume approximately 25% of all drugs prescribed. [2,3]

What compounds this problem is that all patients, but elderly patients in particular, become caught up in an endless cycle of doctor visits to address drug-induced problems. What is problematic for the elderly is that they are often over looked and their medical

complaints, especially those that are medication induced, are often dismissed as simply being part of the aging process. Ageism takes many forms within society and the medical community is certainly not immune from it.

Social Isolation

Social isolation has been defined as ‘’a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and is deficient in fulfilling and quality relationship’’ [4]

Though rates of social isolation among community dwelling older adults are not widely available, reasonable estimates report that up to 20% of older adults currently experience some degree of social isolation but ranges of 10% to 43% are found depending upon the study. [5]

Risk factors for development of social isolation include living alone, having multiple chronic health problems, having no children or family to connect with, lack of access to transportation, low income level, critical life changes such as retirement, changes in family structure such as a change in residence or loss of a spouse or family member and being 80 years of age or older. [6]

Social isolation has been found to be a significant predictor of mortality as shown by a number of studies. It is as strong a predictor of early death as smoking, excessive alcohol consumption or unhealthy diets. Isolated older adults are more likely to experience falls, coronary artery disease, stroke, depression and suicide. Social isolation has been shown to be a significant risk factor for hospitalization and hospital readmission among older adults. [7, 8] Socially isolated older adults are four to five times more likely to be admitted to the hospital than older adults in general**.**

There has also been a correlation made between being socially isolated and the development of dementia and cognitive decline. Along these lines it has been shown that conversely, social inclusion is a significantly protective factor against death and dementia. [5,6,9]

Loneliness

Loneliness is generally defined as a person affected with, characterized by, or causing a depressing feeling of being alone, or lonesome; a person who is destitute of sympathetic or friendly companionship, intercourse, or support; an individual who lives in solitary, without company and companionship.

Loneliness is highly subjective and is often measured using questionnaires that seek perceptions of relationships, social activity, and feelings about social activity. Answers to these will vary for a variety of reasons such as individual perceptions, upbringing, and peer and ethnic group associations to name a few.

Because of this, loneliness is a perception that cannot be objectively observed. Victor et

al (2000) [10] view it as a discrepancy between the actual and desired interaction with others; a perceived deprivation of social contact; a lack of people perceived to be available or willing to share social and emotional experiences; or a state where an individual has the potential to interact with others but is not doing so. Within these definitions of loneliness are external loneliness, which is brought about by a persons life circumstances such as loss of a spouse and internal loneliness that relates more to personality type of the individual. The terms loneliness and social isolation are often used interchangeably or integrated into a definition that endeavors to encompass both of them.

Depending upon the literature consulted, there is somewhat of a debate as to whether poor health causes loneliness and isolation or being isolated and lonely leads to poor health. [11] Regardless, poor health does appear to play a role as a risk factor for the development of both isolation and loneliness. This can occur because of having a reduced capacity to participate in social activities or a loss of independence and ability to communicate with others. Elders with disabilities find additional barriers to interacting socially, which compounds the problem.

A number of intervention strategies have been proposed to counter isolation and loneliness among the elderly such as group activities for bereavement support, becoming more socially active, volunteerism, discussion groups and involvement in community activities. These have met with varying degrees of success but are not universally embraced. [12, 13]

It is important as primary care physicians to ask our elderly patients about their normal activities of daily living (ADL's), social activities or whether they are experiencing loneliness. This is especially important if they are experiencing depression or have just gone through a significant life change of some sort. Often times they will not volunteer the information because their previous physicians have not asked or could not or would not address their concerns when asked. Therefore it is something that should be addressed at each visit.

Ageism and Physician Attitudes

Ageism tends to be multi-faceted, manifesting itself in a variety of ways. These take the form of prejudicial attitudes about the aging process, discrimination against the elderly and social and institutional practices that reinforce stereotypes about the elderly. Ageism can influence the way clinical decisions are made resulting in age related biases and a substandard level of care. [6]

Age bias in medicine takes a variety of forms. Healthcare professionals as a rule do not receive enough training in geriatrics to properly care for many older patients. This is especially seen with specialist care, the group that delivers the most medical care to this cohort.

Older patients, a group identified as needing more preventive care, are less likely than younger people to receive it. Older patients are also less likely to be tested or screened for

diseases and other health problems. Proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment. And older patients are consistently excluded from clinical trials, even though they are the largest users of approved drugs. [14]

Elder Abuse and Neglect

The World Health Organization defines the abuse of older adults as "a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person". [15,16] Elder abuse can destroy an older person's quality of life, and significantly increase their overall risk of death. Elder abuse can take several forms, including physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect. [6]

Most of the care that seniors receive in their later years is provided by a family member, who more often than not, is not adequately prepared to render the care that may be needed. This becomes especially difficult if the elder is depressed, has some dementia or delirium present.

The group of elders most often affected, are women over 75 years of age who are widowed and generally of lower income. The tendency for abuse and neglect increases the older one becomes and is compounded by social isolation, a condition that is becoming increasingly more common.

Abuse tends to be chronic in nature in about 70% of the cases, with periods when it is increased and periods where it is less. There are no racial or socioeconomic distributions and the elderly are often afraid to report or testify against an abuser for fear of retribution or because the abuser is a member of their family.

A family member most often perpetrates abuse of the elder. However, nonfamily or institutional caregivers can be found as well. Often the child who is the least socially integrated sibling ends up being the caregiver or is in the position by default because other family members will not or are unable to take responsibility. Often there is an increased amount of depression found in care givers as well as increases in alcohol abuse and drug use. If violent behavior is found, it is most often a learned behavior as many of the abusers were victims themselves, often at the hands of the elder they must care for.

Physicians must be aware of the signs and symptoms of abuse such as bruises, welts, rope or restraint burns or marks on ankles and wrists. Pallor, dehydration, and weight loss, multiple fractures, or subdural bleeding are flags for ongoing abuse and neglect. If the elder exhibits behavioral signs such as fear and anxiety, obsession with control, or exhibit hostility toward care giver or physician, abuse must be suspected.

If the caregiver presents with excessive concerns about the elderly patient or are constantly harping on the burdens of care giving, suspicion should be raised that there

may be abuse or neglect. If the caregivers explanations of symptoms of the elderly person do not by seem feasible or fit the clinical presentation, this is also a reason to suspect abuse or neglect.

Acute changes in behavioral patterns of the elderly patient not only can signify an occult infectious or metabolic disease but a pattern of abuse as well. Additionally, if the elderly patient presents with unusual conditions such as encopresis or random or unexplained urinary incontinence, abuse or neglect must be considered. [17]

When making assessments of an elderly patient who is now in transition to needing home or assisted care, consider evaluating the caregiver as well. What will the transition of the person becoming the caregiver involve? Is it a sudden transition or has it been present for a while? Was this an expected or unexpected transition? How does it affect their life as well as the person being cared for? Is this a positive or negative experience for them?

What are the characteristics of the caregiver themselves? What is their health status, their ego strength? Do they have any prior experience caring for others? How socially integrated are they, what is their education level, and do they also have a support network?

As primary care naturopathic physicians it is imperative that we treat the whole person, which also includes their family and caregiver. Therefore recognition and intervention for social isolation, abuse and neglect early on is the best strategy for prevention.

Take time to talk with the caregiver and elder at each visit, making sure that either you or someone else follows up if problem areas are identified. Often a counseling referral and frequent follow up visits will put the caregiver and elder at ease.

Recognize the needs of the caregiver and help develop care and coping strategies with them. Provide options such as senior or state social services or help with respite care for the care provider.

If abuse is uncovered, report all abuses to Elder Protective Services or other social agencies. Be prepared to testify if needed and be able to back up your claims with medical evidence from your examination. Referral to other physicians or referral to an emergency room for documentation may be necessary in order to establish abuse.

Recognizing and addressing elder abuse, neglect and loneliness early on will help to provide a better quality of life in their later years.

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