

Title: Elder Mistreatment: Perspectives from a Medical Resident in the United States.

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Introduction:

Approximately one in ten Americans have experienced elder abuse, yet a study estimated that only one in twenty-four cases are reported to authorities. Older adults facing mistreatment are at higher risk of death, hospitalizations, depression and anxiety, and present to the emergency department more frequently. Risk factors for elder abuse include cognitive impairment, dependence on caregivers and social isolation. Despite the high prevalence, several factors could contribute to under-reporting: limited education and awareness of elder abuse, lack of clarity about reporting procedures and legal requirements, and fear that reporting could affect therapeutic relationships with patients and family.

Types of Mistreatments, their warning signs and clinical screening

Elder mistreatment can be categorized into physical, emotional or psychological, neglect, financial and sexual. Each type has distinct but overlapping warning signs and may present in combination. Clinicians can reference “red flag” checklists developed by international and national organizations.

Physical Abuse: Physical abuse requires a consistently high index of suspicion. Bruises approximately 2 inches in diameter or larger, and on the face, lateral arm or back should raise suspicion for mistreatment and prompt further evaluation (Wiglesworth *et al.*, 2009). Other red flags include open wounds, cuts, untreated injuries, physical signs of being restrained, or an older adult’s report of being assaulted or mistreated.

Clinicians should ask how the injuries were sustained, and care should be taken to interview the patient alone. Inconsistencies between the patient’s and caregiver’s account, or physical findings discordant with the mechanism of injury should be red flags. Older adults with cognitive impairment including dementia should not be excluded from direct questioning about their bruises.

Emotional / Psychological Abuse: Emotional elder abuse is the infliction of distress, anguish or pain through verbal or non-verbal acts (USC Center for Elder Justice [USCCFEJ], 2025). It can be challenging to identify, especially with complex care needs. Social isolation is one of the main risk factors and should heighten concern. New signs of depression or anxiety, changes in behavior, or restriction of communications with friends and family can be subtle signs. Other signs include deferring questions to a caregiver or potential abuser.

Neglect: Elder neglect is the failure of a caregiver to provide necessities such as food, water, shelter or medicine (USCCFEJ., 2025). Clinical signs such as malnutrition, dehydration, poor personal hygiene or poor adherence to medications should bring attention to neglect. Concerns should be raised if the older adult is left alone despite clear safety risks, or if they are living in an unsafe or unsanitary setting. A thorough interview with the primary caregiver, physical

examination, and nutrition screening should be performed. It is important to note that neglect may be unintentional due to the caregiver's own frailty, medical illness, or limited health literacy.

Financial Exploitation: Financial exploitation can be one of the most difficult forms of abuse to detect (Wood, 2014). It involves the unauthorized use of an older person's money, or the improper use of conservatorship, guardianship or power of attorney. Because financial abuse is often hidden, direct but sensitive questioning is crucial. Examples include: "Has money been taken from you without your consent?" or "has anyone pressured you to sign documents or change your will?" Older adults often live on fixed incomes while facing increasing healthcare costs; financial exploitation can be devastating and difficult to recover from (Nguyen *et al.*, 2021). Early recognition is crucial to limiting the damage and connecting patients with necessary support.

Sexual Abuse: Being an older adult does not reduce one's vulnerability to sexual abuse (National Center of Elder Abuse [NCEA], 2025). This ageist assumption is itself a barrier to detection and contributes to missed opportunities for interventions. Women are at higher risk. Clinical signs include urinary tract infections, sexually transmitted diseases, genital rash or redness, unexplained pelvic pain or bleeding. Behavioral changes such as new hypersexual behavior, fearfulness, or a withdrawn, blunted effect may be clues (Lachs *et al.*, 2015). Incorporating a routine, non-judgement sexual history into medical assessments can normalize the topic and provide an opening for disclosure. This is crucial as survivors do not typically report offenses to healthcare providers (NCEA, 2025). Clinicians should be vigilant to avoid assumptions about an older person's sexuality, capacity or "likelihood" of being abused.

Our role as medical residents:

Our primary responsibility is to ensure patient safety and reduce harm. This includes recognizing, responding to, and reporting suspected elder abuse. It is important to note that most states in the U.S. require physicians to report suspected elder abuse, neglect, or exploitation to Adult Protective Services (APS), or the equivalent authority.

APS programs are authorized in every state to investigate reports of elder maltreatment and to promote safety, independence and quality of life for older adults. Importantly, a report to APS does not mean that the patient will be automatically removed from their caregivers; The purpose of mandatory reporting is to assess risk, mobilize appropriate services, and implement harm-reduction strategies (NCEA, 2024).

For residents, the legal and procedural landscape can feel daunting. However, there are practical strategies that can guide daily practice:

- **Building knowledge and clinical vigilance:** Familiarizing ourselves with the common types of elder mistreatment (physical, emotional, sexual, financial, neglect), their risk factors, and red-flag signs. Integrate this into routine clinical reasoning instead of treating it as an "extra" consideration. If risk factors or concerning signs are identified, and you have reasonable suspicion of abuse, a more thorough assessment should be undertaken in cooperation with an attending and a multi-disciplinary team. As mandated reporters, we have a duty to take

suspected abuse seriously: conduct a careful assessment, document concerns, and report any reasonable suspicion so that the protective response can be activated.

- **Channel local resources:** Identify your local pathways, including how APS reports are made in your state and how institutions expect residents to escalate concerns. Keep an accessible list of key contacts: social work, APS hotline, legal/risk management, and community agencies. Leverage interprofessional teams (physicians, social workers, law-enforcement, etc.) whenever possible. Framing the response as “How can we reduce this patient’s risk and improve their safety and quality of life?” keeps the focus patient-centered rather than purely investigative.
- **Challenging ageist and other implicit biases:** 1 in 5 Americans over age 50 experience ageism in healthcare (Rogers et al., 2015). As physicians, we have a role in creating a more inclusive healthcare system for older adults. This starts with reflecting on how we think and act towards oneself and others based on age, while avoiding ageist language and assumptions. For example, changes in mood in an older adult are often attributed to age, but differential diagnoses could include depression, dementia or a subtle sign of elder abuse. Residents can take steps to engage in formal education about implicit bias and ageist thinking.

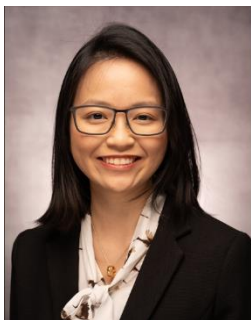
Conclusion:

With improved knowledge and awareness, residents can contribute to the safety of elders. It is important to consider elder abuse as a differential during our patient encounters, recognize risk factors and signs, and remember that the ultimate goal is for harm reduction and improving safety through setting up supports while prioritizing the independence and safety of our vulnerable older adults. This starts with creating a clinical culture where older adults are seen as fully deserving of safety, dignity, and attention to their concerns.

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Biography:



Zhu is a second-year internal medicine resident at Saint Vincent Hospital in Worcester, Massachusetts. Her clinical and academic interests focus on the care of older adults, and she plans to pursue a geriatric medicine fellowship in 2027 with the goal of a career as a geriatrician. Zhu completed medical school and part of her internal medicine training in Australia before relocating to the United States in 2023. Email: ngzhuchin@gmail.com.