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Recognizing Elder Mistreatment: A Guide for Courts

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The crime of elder abuse takes many forms: financial, emotional, sexual, and physical abuse, as well as neglect. In many (perhaps most) circumstances, multiple forms coexist and this is referred to as polyvictimization. As in child abuse and domestic violence, people who are victimized tend to be vulnerable for a variety of reasons that span from physical to cognitive to psychological domains. This article outlines several aspects of age-related physical changes and highlights those features of aging that can make an older adult susceptible to elder abuse and neglect. We will go on to describe physical manifestations and laboratory markers, as well as the role of medication in abuse and neglect. Finally, we will address the topic of capacity. Throughout the article, we will indicate how knowledge in these areas can enhance the functions of the court in cases of suspected elder abuse and neglect.

I. INTRODUCTION

A. BACKGROUND

There are more than 41 million Americans currently over the age of 65, and with 10,000 people turning 65 every day, older adults comprise the fastest growing portion of the U.S. population. Recent studies have shown that at least one in ten Americans over the age of 60 has experienced abuse and many have experienced multiple forms of abuse.[1] Another study found that nearly half of people with dementia experience abuse.[2]

With this dramatic rise in the number of older adults coupled with ongoing efforts to identify, report, and prosecute elder abuse cases, our U.S. courtrooms will see an increase in the volume of cases involving some form of elder abuse or neglect. Although facts and evidence in an elder abuse case are usually complex, the decision of the court often rests on whether the injuries are caused by abuse or neglect versus a result of normal aging processes and/or an accident. Medical evidence including photos of injuries, laboratory reports, and medical documentation can be introduced as evidence. Understanding the difference between normal aging and markers for abuse and neglect is essential to recognizing abuse and evaluating the evidence that is presented.

Other functions of the court involve adjudicating cases that require guardianship and conservatorship decisions on behalf older adults who perhaps are no longer capable of making decisions on their own behalf. Tests evaluating cognition, capacity, and functional ability are a mainstay of testimony and evidence in these cases and all may contribute to making a decision that best serves the older adult. There are a variety of experts who may provide testimony in court. Familiarity with their training and areas of expertise can contribute to a better understanding of professional testimony and a discerning eye as to the appropriateness of a geriatric professional in addressing a particular question.

All of us make assumptions and have biases, be they conscious or unconscious. Our attitudes, experiences, backgrounds, assumptions, and fears about aging and older adults and family violence may lead to misconceptions that negatively impact an older adult during a trial. It is therefore important to be aware of our own predispositions and to be knowledgeable about the basics of aging so that we can understand common myths and misconceptions as such. Some common misconceptions are:

- Old people bruise easily therefore it's not possible to tell if someone hit them
- It's expected to get pressure sores when you're at the end of life
- People with dementia don't feel pain
- It's normal for old people to be confused

Example: A 92-year-old woman is pushed into the courtroom in a wheelchair. She is hunched over due to osteoporosis and is unable to look up. She looks a little disheveled and presents as a tiny body in a big chair. She gives the impression of being frail and weak. It does not seem possible to those around her that she actually is one of the sharpest people in the room. If accommodations to assure she can hear the proceedings, see the goings on, and be heard by people in the courtroom are not made, it may simply validate an assumption of her incompetence without questioning the initial perception.

B. TERMINOLOGY AND TYPES OF PROFESSIONALS

Frequently in cases that involve allegations of elder abuse or neglect, professionals with advanced training in the aging process are referenced in documents and called upon for their technical skills in court proceedings. Terminology and titles can be confusing; several disciplines have overlapping areas of expertise and a particular discipline or title without requisite experience does not guarantee appropriate proficiency. For example, several different specialties may have the background (training, skills, knowledge, experience) to make an evaluation of cognitive abilities. Physicians, including geriatricians, neurologists, and psychiatrists, may be able to make a determination, as well as psychologists who specialize in geropsy-

Footnotes

1. Edward O. Laumann, Sara A. Leitsch & Linda J. Waite, *Elder Mistreatment in the United States: Prevalence Estimates from a Nationally Representative Study*, 63 J. GERONTOLOGY SERIES B S248 (2008).
2. Aileen Wiglesworth et al., *Bruising as a Marker of Physical Elder Abuse*, 57 J. AM. GERIATRICS SOC'Y 1191 (2009).

chology or neuropsychology. Geriatric professionals involved in courtroom proceedings should have both the technical training and experience as a practitioner if they are going to be involved in the often life-altering decision that goes along with a capacity assessment.

Many scholarly and professional fields focus on older adults. *Gerontology* is the study of aging and older adults. It is a diverse field that includes the study of physical, mental, and social changes in people as they age, changes in society due to an aging population, and how this knowledge can be applied to policies and programs. People can get masters degrees and PhDs in gerontology. *Geriatrics* is the study of health and disease in later life. It includes the health care of older people, as well as the health and well-being of their caregivers. Many types of professional fields have advanced training in geriatrics. Of those, primary care physicians, psychiatrists, pharmacists, nurse practitioners, and psychologists are the most commonly involved in the in evaluation and testimony in elder abuse cases.

While many primary care physicians who provide care for older adults may have expertise by virtue of their experience and independent study, only board-certified geriatricians have completed a fellowship and passed a certifying exam as experts in the assessment and medical care of older adults. Just as a pediatrician specializes in care of children because children are not simply small adults, a geriatrician specializes in care of older adults because of the unique health care needs of this population. One of the most important things that a geriatrician can contribute to an alleged elder abuse case is the ability to make both cognitive and physical assessments of alleged victims of abuse. Additionally, geriatricians are able to review prior medical records for signs of abuse or neglect, as well as screen for modifiable signs of cognitive impairment such as delirium or medication side effects.

Similarly, *geropsychiatrists* or *geriatric psychiatrists* have completed a fellowship and passed a certifying exam. They have special expertise in normal and pathologic changes in mental health and cognition that can occur with aging. Both geriatricians and geropsychiatrists have received special training to address the different health problems that older adults may face compared to younger people. These professionals may provide necessary evaluations for suspected elder abuse victims and offer expert testimony to assist in cases of suspected elder abuse.

In the field of psychology, there are two particularly relevant subspecialties. A *neuropsychologist* specializes in the applied science of brain-behavior relationships. A *geropsychologist* specializes in the cognitive, behavioral, and developmental changes that occur with aging. Neuropsychologists are usually board certified through the American Board of Clinical Neuropsychology. Board-certified geropsychologists must complete formal geropsychological training and pass a national board certification. Both a neuropsychologist and a geropsychologist are well-qualified to determine issues such as decision-making capacity and to assist with assessing and understanding an older person's cognitive function with relation to their ability to provide consent. Like their physician colleagues, a geropsychologist may have the ability to assess, retrospectively, cognition by reviewing past records and interviews.

The most common injuries of physical abuse are abrasions, bruises, skeletal fractures, and head injuries.

Typically, geropsychologists conduct a cognitive assessment with a battery of validated tests to determine the degree of impairment in different cognitive domains, including executive functioning, attention, memory, and concentration, among others. This testing evaluates the alleged victim's relative strengths and weaknesses in these various cognitive domains. Understanding how other factors of mood and mental health may be impacting an older adult's functioning and cognition is another important part of evaluation performed by a geropsychologist.[3]

Because medication often plays an important role in the cognition and function of an older adult, a *geropharmacologist* may be engaged in evaluating medications used by an alleged victim of elder abuse. Through training geropharmacologists understand how age-related physiological changes affect medication therapy in older adults and evaluate for appropriate dosing and use of medication

II. NORMAL AGING AND ACCIDENTAL/INCIDENTAL INJURY VS. MARKERS OF ABUSE

Heterogeneity is the hallmark of aging; the older we get, the more different we become. The influence of environmental, genetic, and lifestyle factors accumulate in different ways for different people. Many older adults are healthy and active, while others are more frail and disabled by ill health. Yet all of us experience some physiological changes as we age. These factors combine and contribute to a slew of normal and common age-related changes that can make it difficult to detect or prove abuse and neglect. In fact, it is usually possible to find a reason *other* than abuse or neglect to explain a fracture, bruise, or pressure sore. Skin and bones become more fragile as the human body ages, making older adults more vulnerable to injury. Medications and declining functional abilities are additional variables that can contribute to increased susceptibility to injury. For example, medications known as "blood thinners" may cause older adults to bruise more easily (although some trauma is still required to rupture the blood vessel) and create more pronounced bruising. In addition, when older adults take skin-thinning medications, like steroids, tears can happen more easily. Changes in gait and balance make an older adult more likely to stumble or fall, which can result in a number of injuries like abrasions (scrapes) or lacerations (cuts), or even fractured bones.

3. Erika Falk et al., *Geriatricians and Psychologists: Essential Ingredients in the Evaluation of Elder Abuse and Neglect*, 22 J. ELDER ABUSE & NEGLECT 281 (2010).

A delay in seeking medical attention for severe injuries should trigger consideration of physical mistreatment.

The most common injuries of physical abuse are abrasions, bruises, skeletal fractures, and head injuries. Knowing the difference between a common age-related accidental or incidental injury and a marker for abuse or neglect requires being keenly aware of the subtle differences in the location, pattern, and context of these injuries. Several of these injuries, like abrasions and bruising, can retain the pattern of an object used to inflict the injury and give insight into the cause of the injury. Injury location on the older adult's body is an important factor in determining the cause of injury. Any injury to the eyes, nose, or mouth are less likely to be accidental.[4] Generally, injuries in areas of the body that are not commonly impacted during daily activities should arouse suspicion for abuse.[5] For example, abrasions sustained through accidental or incidental injury are most often found on limbs. Similarly, skin tears are more likely to occur on forearms and less frequently on legs. Individuals generally have less than one or two of these injuries at a time when there is no abuse. Evidence of skin tears and abrasions in sites other than arms or legs or multiple tears should raise suspicion for potential mistreatment.

A. BRUISING

Likewise, accidental bruises occur in predictable places with over 90% found on the extremities.[6] Despite popular perception, the color of a bruise is not an accurate predictor of its age.[7] Size also matters. Frequently, larger bruises (> 5 cm) more commonly appear on older adults who have been abused. All older adults with at least one bruise larger than 5 cm or bruising on the head, neck, ears, lateral right arm, or posterior trunk, genitalia, buttocks, or the soles of the feet should trigger concerns for elder mistreatment.[8] Other considerations of location and pattern include abrasions and or bruising around the wrists or ankles, which may signal the use of forcible restraint. [9] Bruising patterns suggestive of defensive postures or related to grasping or squeezing should also prompt suspicion.[10] Judges will likely need expert testimony to make any conclusions, but awareness of what to look for may prompt appropriate questions to guardians or referral to an expert.[11]

B. AGE-RELATED BONE CHANGES AND MARKERS FOR PHYSICAL ABUSE

Beginning around the age of 30, there is a steady decrease in bone density. For women there is accelerated loss around the time of menopause. If bone density declines beyond a certain point, defined using DEXA (dual energy x-ray absorptiometry) scanning, it is called osteopenia. A further decline may result in the disease known as osteoporosis. As bone density decreases, the ease with which a trauma can cause a fracture increases. A fall that might have resulted in nothing more than embarrassment at the age of 45 may result in a hip fracture at the age of 85. Frequently, an older adult is diagnosed with a fracture due to an accidental fall. The bone injuries most commonly sustained by older adults from accidental injury or fall include vertebral fractures and hip fractures for those over the age of 75 and wrist fractures for women under the age of 75.[12] Generally, fractures that are not hip, upper arm, or vertebral fractures should give pause to consider whether mistreatment played a role in the injury.[13] Specifically, fractures anywhere on the face, including around the eyes, the nose, or jaw, can be a sign of blunt force trauma.[14] Fractures of the skull, cervical spine, and ribs are more likely a result of physical assault than limb fractures. Although a spiral fracture, even of a large bone found in the limbs, may signal that the mechanism of the injury involved a twisting force, which is highly suggestive of abuse.[15]

Often, older adults that are victims of abuse will have multiple injuries in various stages of healing. A delay in seeking medical attention for severe injuries should trigger consideration of physical mistreatment.[16]

C. PRESSURE ULCERS

Pressure ulcers, also called "pressure sores" or "bed sores," are localized injuries to the skin and/or underlying tissue caused by pressure, or pressure combined with a shearing force, typically over a bony prominence.[17] When establishing whether pressure ulcers are a result of neglect there are a num-

4. Kim A. Collins, *Elder Maltreatment: A Review*, 130 Archives Pathology & Laboratory Med. 1290 (2006).
5. *Id.*
6. Laura Mosqueda, Kerry Burnight & Solomon Liao, *The Life Cycle of Bruises in Older Adults*, 53 J. Am. Geriatrics Soc'y 1339 (2005), *available at* http://www.centeronelderabuse.org/docs/LifeCycleBruisesOA_MosquedaBurnightLiao2005.pdf (last visited June 21, 2017).
7. *Id.*
8. See Wiglesworth et al. *supra* note 2.
9. Carmel Bitondo Dyer, Marie-Therese Connolly & Patricia McFeeley, *The Clinical and Medical Forensics of Elder Abuse and Neglect*, *in* Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America 339 (Richard J. Bonnie & Robert B. Wallace eds., 2003).
10. Brogdon's Forensic Radiology 322 (Michael J. Thali, Mark D. Viner & B.G. Brogdon eds., 2nd ed. 2010).
11. More information about bruising patterns, including diagrams of bruising patterns, can be found in Mosqueda et al., *supra* n. 6.
12. See Dyer et al. *supra* note 9.
13. See Collins, *supra* note 4.
14. *Id.*
15. Lisa M. Young, *Elder Physical Abuse*, 30 Clinics Geriatric Med. 761 (2014).
16. See Thali et al. *supra* note 10.
17. Mary H. Palmer, *Pressure Ulcers: Practical Considerations in Prevention and Treatment*, *in* Reichel's Care of the Elderly: Clinical Aspects of Aging 509 (Jan Busby-Whitehead et al. eds., 7th ed. 2016).

ber of confounding factors. Conditions that affect one's mobility, such as advanced stage dementias, Parkinson's disease, stroke, frailty, and deconditioning, all increase the risk of a pressure sore. Other contributing factors include moisture, malnutrition, and impairment of the microcirculatory system due to acute or chronic illness.[18]

Pressure ulcers are categorized using four stages with stage 1 being the least severe and stage 4 being the most severe.[19] At stage 1, a pressure ulcer is a nonblanchable and reddish section of intact skin. At stage 2, a pressure ulcer is a shallow open ulcer with a clean red wound base. At stage 3, a pressure ulcer appears as a deeper ulcer with subcutaneous fat and may include undermining and tunneling. At stage 4, the pressure ulcer is the deepest and may expose tendons, muscles, and even bone. Some ulcers may be unstageable due to superficial coverings of slough or eschar. This covering must be removed before an ulcer can be staged. In addition, suspected deep tissue injuries are categorized as a localized area of purple or maroon colored skin or blood-filled blister due to damage of underlying soft tissue. In this case, the injury begins at the bony prominence or deep tissue layer and spreads to the skin.[20]

Pressure ulcers are more common in older adults who are immobile, but caregivers should assist in ulcer prevention by using good care management techniques, including repositioning pressure-sensitive areas of the body every 2-3 hours.

Markers of neglect include pressure ulcers associated with malnutrition and/or dehydration, which hasten skin breakdown. Another marker for neglect is an immobile older adult who is left alone for extended periods and is unable to get to the bathroom or reposition himself or herself. In these situations, the older adult often develops avoidable pressure ulcers due to skin breakdown from constant exposure to excess moisture and bacteria from urine and feces, as well as decreased circulation in the skin around bony prominences.

However, because pressure ulcers may develop regardless of adequate care management techniques, an expert should evaluate them to determine whether neglect could be a contributing factor.[21]

III. AGE-RELATED SENSORY CHANGES IN THE OLDER ADULT

Decreased visual and auditory acuity are common age-related occurrences and can present multiple challenges and vulnerabilities for the older adult. Age-related hearing loss, known as presbycusis, is experienced by more than 50% of people over 75 years old, and nearly all adults who are 90 years or older.[22] Diminished hearing may make it difficult to follow conversations or directions. If an older adult does not acknowledge his hearing loss or if it is not known to be a problem, he may seem to be cognitively impaired when, in fact, his apparent confusion is due to the hearing difficulty.

Special accommodations should be taken in the courtroom to help older people with vision or hearing loss to assist with more complete and accurate testimony.

Common age-related conditions that reduce visual acuity include presbyopia, cataracts, glaucoma, and macular degeneration. Presbyopia is the term used to describe an inability to see clearly at an arm's length or closer. Without corrective lenses, this condition limits the ability for an older person to read a document. Cataracts are the gradual clouding of the lens, which, without intervention, over time can completely obscure vision. It is easily treatable through outpatient surgery with a very high likelihood of a successful outcome. Macular degeneration is a loss of central vision, making things look shadowy or fuzzy, and it can result in blindness over time although some forms are amenable to treatment. Glaucoma causes gradual vision loss over time due to elevated pressure inside the eye and, if not treated, can cause blindness.[23] A person with glaucoma may experience blank spots in their vision and eventually tunnel vision as the optic nerve becomes increasingly damaged. A compromise in visual acuity can cause the older adult to become more vulnerable to mistreatment due to a diminished functional ability in reading, driving, or other activities that are important for independent functioning. Significant loss in vision may compromise one's ability to identify an assailant or to read a legal document.

Special accommodations should be taken in the courtroom to help older people with vision or hearing loss to assist with more complete and accurate testimony. Providing more light or magnification, or having something read aloud, may assist a person with vision loss. For people with significant hearing loss people should speak as clearly as possible, allowing the older adult to see their lips. If personal hearing aids are not available or helpful, other amplification devices such as a Pocket Talker are small, simple, and inexpensive, and are readily available. In cases of extreme hearing loss, written communication may be best.

IV. FUNCTION

Frailty is recognized as a medical syndrome characterized by symptoms such as fatigue, weakness, slowed walking speed, weight loss, and a low level of physical activity. Older persons

18. *Id.;* Lisa M. Gibbs, *Understanding the Medical Markers of Elder Abuse and Neglect: Physical Examination Findings*, 30 CLINICS GERIATRIC MED. 687 (2014).
19. For a set of color diagrams showing each stage of pressure ulcers, see *Stages of Pressure Sores*, WebMD, *available at http://www.webmd.com/skin-problems-and-treatments/four-stages-of-pressure-sores* (last visited June 21, 2017).
20. Gibbs, *supra* n. 18.
21. *Id.*
22. A.C. Davis, *Epidemiological Profile of Hearing Impairments: The Scale and Nature of the Problem with Special Reference to the Elderly*, 111 ACTA OTO-LARYNGOL (SUPP. 476) 23 (1990).
23. Rawan Tarawneh & James E. Galvin, *Neurologic Signs in the Elderly*, *in* BROCKLEHURST'S TEXTBOOK OF GERIATRIC MEDICINE AND GERONTOLOGY 101 (Howard M. Fillit, Kenneth Rockwood & Kenneth Woodhouse eds., 7th ed. 2010).

who are frail are also more vulnerable to abuse and less able to recover from illness and trauma.

When assessing for possible abuse or neglect, understanding a person's functional status is critically important. Clinicians who make these assessments often divide a person's functional activities into two categories: Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs). IADLs are those activities linked to independent living in the community. These include handling one's own finances, managing medications, driving or taking public transportation, and preparing meals. If a person requires assistance with some of these activities that can often be arranged through family, friends, or paid assistance.

ADLs are those activities needed to live independently in one's own home. Activities of daily living include feeding oneself, toileting, mobility, dressing, and bathing. People who are independent with ADLs may be able to remain in their own home with assistance with things such as meal preparation and transportation. However, if a person requires assistance with these basic activities of daily living, then in-person help is likely required for them to remain at home safely.

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
Eating/feeding oneself	Meal preparation
Toileting	Housekeeping
Mobility	Laundry
Dressing	Shopping
Bathing	Managing personal finances
Continence	Managing medications
Grooming	Use of transportation
	Use the telephone or other communication devices

Example: An 81-year-old woman (Mrs. G) was brought to the emergency room with a swollen tender ankle. Radiographs showed a fracture of the distal tibia and fibula (the two bones in the lower leg, close to where they articulate with the foot). Mrs. G had advanced Alzheimer's disease and was unable to say how this injury happened. Her primary caregiver, a daughter, said that Mom fell out of bed yesterday and she rushed her to the hospital as soon as she noticed the injury this morning. Upon examination it was noted that she also had pressure sores on her buttocks and bruising on her upper arms.

When information regarding Mrs. G's functional status was obtained it was learned that she required assistance with almost all activities of daily living. How would somebody who is unable to get out of bed by herself fall and fracture her lower leg? Moreover, the presence of a pressure sore means that she has very limited mobility while in bed and so even falling out of bed would be a highly unlikely event. This is a circumstance in which we have an older adult who was unable to give a history due to her cognitive impairment but in which physical findings do not correlate with the story provided by the caregiver. It is also easy to imagine that if she was brought to the emergency room the story of a confused older woman with osteoporosis and a broken bone might not raise any suspicion.

V. MEDICATION MISUSE

As we age the body's response to medication changes. Pharmacokinetics, the way in which the body absorbs and eliminates medication, and pharmacodynamics, the way in which medication is distributed and acts on our bodies, are both altered as a normal part of the aging process. Illnesses such as kidney disease and liver disease may further exacerbate these changes, making older adults exquisitely sensitive to side effects such as confusion, sedation, dizziness, unsteadiness, agitation, loss of appetite, and constipation. While medications play an important role in curing or treating disease, they become toxic and dangerous when dosed improperly. Seemingly small changes in medication management can have the potential to cause severe harm. Sometimes medication misuse happens unintentionally, which might be indicated by an isolated instance rather than an extended pattern of purposeful misuse.

Medication can be used as a weapon or tool of control. Overuse, underuse, and misuse of medication are all methods used in abuse or neglect. Overuse occurs when a medication is prescribed for an indicated purpose, but is purposely given in too high a dosage or too frequently to accomplish a goal such as causing confusion.

Example: Mrs. H was an 88-year-old woman with severe pain due to advanced rheumatoid arthritis. Her doctor had appropriately prescribed a narcotic pain medication (codeine) for use at times when the pain was very severe. Noting that the medication caused her to be confused, her daughter used this as a tool for financial abuse: she surreptitiously added the codeine to Mrs. H's food and then had her sign checks.

Withholding a medication (underuse) is another way to abuse an older adult.

Example: Mr. B had Parkinson's disease and required regular doses of a medication levodopa-carbidopa (Sinemet) to walk. Without that medication he was stiff and barely able to move. His daughter-in-law, who was unhappy about having him in her house, often withheld the medication so that he could not get around the house. Eventually Mr. B was unable to get out of bed and developed large, deep pressure sores as a result of this immobility and bone pain due to metastatic prostate cancer. He was bed-bound, on hospice, and was supposed to be receiving morphine on a regular basis to keep the pain controlled. His son would sometimes not provide the medication as a punishment when he felt his father was being too demanding or burdensome.

VI. DECISION-MAKING ABILITY: COGNITION AND CAPACITY

The concept of impaired decision making is a frequent issue in elder abuse cases. People who are impaired are at higher risk of being abused and in turn may be unable to understand or to report abuse. On the other hand, respecting and defending a person's autonomy is a cherished principle. The gray area of "everyone has a right to make a bad decision" becomes closer to black and white when a person is obviously demented. Cognition and capacity are important concepts related to decision-making ability. Psychosocial factors are also important to consider because depression, reduced feelings of well-being, lower levels of social support, or loneliness may also increase risk of elder abuse.[24]

Cognition is a term that encompasses many brain functions, including complex attention, executive function, learning and memory, language, perceptual-motor skills, and social cognition. Normal aging is accompanied by structural and functional brain changes that may only become apparent under stressful circumstances such as highly technical or fast-paced environments or unfamiliar and stressful situations,[25] such as appearing in a courtroom.

Complex attention – The ability to pay attention or focus on a specific stimulus in an environment with multiple stimuli; the ability to recall new information, such as reporting what was just said.
Executive function – The ability to plan, make decisions, hold information briefly in memory to manipulate, respond to feedback, or demonstrate mental flexibility.
Learning – The acquisition of skills or knowledge.
Memory – The expression of learned skills or knowledge.
Language – The ability to speak or understand spoken or written language.
Perceptual-motor skills – The ability to interact with the environment by combining the use of senses and motor skills.
Social Cognition – The ability to recognize others' emotions or what they are thinking.

Capacity is related to but not the same thing as cognition. Capacity refers to a continuum of decision-making abilities.[26] Capacity is sometimes broken down into two main types: decisional capacity and executional capacity. *Decisional capacity* refers to a person's ability to complete a specific task or make a specific decision such as driving a car or refusing medical treatment.[27] *Executional capacity* refers to a person's ability to implement a decision such as the ability to manipulate money, pay bills, or maintain a checkbook.[28] Capacity may impact decisions that older people make in regards to their health, finances, and other areas of their lives. Capacity is rarely an all-or-none phenomenon: while an older adult may lack capacity in one area, he or she may retain it in others.

When an older person's decision-making ability seems compromised, a medical evaluation to review their physical and psychological status should be conducted to reveal any conditions that may benefit from treatment. It is important to see if capacity can be restored rather than assume that it is a permanent condition. Sometimes capacity may not be fully restored but may be improved such that an older adult is able to participate in some decisions.

Dementia, called "major neurocognitive disorder" in the DSM 5, is a syndrome in which a person has difficulty in one or more cognitive domains such that he is unable to do his usual activities such as paying bills or preparing meals. While Alzheimer's disease is often used as the prototypical dementia, it is important to recognize there are many causes of dementing illnesses. Alzheimer's disease and vascular dementia (dementia due to strokes or chronic lack of adequate blood flow to the brain) are the most common causes of dementia. Both impair memory and executive function in the early stages. Another type of dementia called Frontotemporal lobe dementia causes profound changes in personality in the early stages along with memory loss. Lewy Body dementia is characterized by memory loss, visual hallucinations, and muscle rigidity in its early stages.

No matter the cause of the dementia, a variety of things can cause excess disability. These include untreated (or inadequately treated) illness such as thyroid disease, medication side effects, and/or metabolic abnormalities. A person with Alzheimer's disease who is hypothyroid (a low thyroid condition) and depressed may have a significant amount of decision-making capacity restored when both of those conditions are adequately treated even though the underlying dementia remains. Trained clinicians use standardized capacity interviews and cognitive assessment tools along with structured interviews to help determine a person's capacity to make a particular decision at a particular time. It is common to be asked to determine a person's capacity at a time several years before appearing in court based on a review of records and a present-day assessment. While this is not always possible to do, there are times when it can be accomplished with a high degree of accuracy. For example, the trajectory of Alzheimer's disease is such that a person with advanced dementia would not have had capacity to consent to a complicated financial transaction one year ago.

Decision-making ability fluctuates over time and with changing external factors.[29] With the help of trained clinicians,

24. R. Nathan Spreng, Jason Karlawish & Daniel C. Marson, *Cognitive, Social, and Neural Determinants of Diminished Decision-Making and Financial Exploitation Risk in Aging and Dementia: A Review and New Model*, 28 J. Elder Abuse & Neglect 320 (2016).
25. Inst. of Med., Cognitive Aging: Progress in Understanding and Opportunities for Action (2015)
26. Jennifer Moye & Daniel C. Marson, *Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research*, 62 J. Gerontology Series B P3 (2007).
27. Michelle Braun & Jennifer Moye, *Decisional Capacity Assessment: Optimizing Safety and Autonomy for Older Adults*, 34 Generations 102 (2010).
28. Patricia A. Boyle et al., *Cognitive Decline Impairs Financial and Health Literacy Among Community-Based Older Persons Without Dementia*, 28 Psychol. & Aging 614 (2013).
29. Erika Falk & Nancy Hoffman, *The Role of Capacity Assessments in Elder Abuse Investigations and Guardianships*, 30 Clinics Geriatric Med. 851 (2014).

For older adults who depend on a caregiver to administer medications, significantly abnormal laboratory values may be a marker of abuse or neglect.

judges should understand how cognition and capacity are relevant to decision making and be able to recognize signs of abuse while simultaneously promoting and maintaining autonomy.

Example: A 72-year-old man with end-stage prostate cancer is being cared for by his 38-year-old son. He is on hospice and has morphine available for pain control. Another family member finds him at home alone one day and sees that he appears to be emaciated and in a great deal of pain. He is taken to the hospital where blood tests reveal severe dehydration and malnutrition. It was also noted that there were no detectable levels of morphine in his blood; however, there was regular resupply of morphine through the hospice agency. It was finally determined that his son was using and selling morphine rather than giving it to his father. When the father was fed and hydrated, and his pain was controlled, he regained his decision-making capacity.

VII. LABORATORY FINDINGS

There are a variety of conditions that can be discovered or suspected based on laboratory data, such as malnutrition and dehydration. It is important to interpret blood test results in the context of the person's medical conditions and medications.

Abnormal laboratory findings can be suggestive of mismanagement of chronic illnesses. For example, people with diabetes are expected to have their hemoglobin A1C within a certain range. If this test is markedly above an acceptable level, it suggests poor control of diabetes. Similarly, people who are on anticoagulant medications such as warfarin should have a laboratory test to assure that they are receiving the correct amount of medication. For older adults who depend on a caregiver to administer medications, significantly abnormal laboratory values may be a marker of abuse or neglect.Overdosing or underdosing medications may also be picked up on the blood test.

VIII. SEXUAL ABUSE

Both men and women experience physical changes that can contribute to increased potential for injury during intercourse. A reduction in hormones can diminish erections in men and increase fragility of the vagina, which can lead to injury even during consensual sex. As with other forms of abuse, it is important to distinguish between intentional injury and incidental minor trauma from a consensual sexual interaction due to physical changes of the aging body.

Older adults are sexually responsive and participate in a variety of consensual sexual activities. Society tends to view older adults as asexual, which contributes to the fact that sexual abuse is one of the least acknowledged, detected, and reported forms of elder abuse.[30] Cognitive decline, as well as diminished physical strength and ambulatory ability, can make an older adult more vulnerable to sexual abuse. As seen in younger populations, sexually abused older adults experience internalized shame and self-blame, which can contribute to a hesitancy to report abuse.[31]

Like other forms of physical abuse, there are markers that raise the suspicion of sexual abuse. Physical injuries to the mouth (hard and soft palate injuries), breasts, inner thighs, and anogenital regions, including lacerations, abrasions, and bruising, should evoke suspicion for sexual mistreatment. In cases of sexual abuse, it is common to find additional trauma in non-genital areas such as bite marks, blunt force trauma, and secondary injuries caused by the use of restraints or suffocation.[32] Evidence of vaginal or ano-rectal bleeding should trigger further investigation to rule out sexual abuse. Lab tests that show evidence of semen may also contribute to evidence of sexual abuse.[33]The development of a sexually transmitted disease in an older adult who is unable to consent for sexual relations or denies participating in sexual relations also raises concern for abuse.[34] Not all sexual abuse will leave a physical marker. In fact, unwelcome sexualized kissing or fondling remain the most common form of sexual abuse.[35]

Physical abuse, neglect, and sexual abuse can all create significant emotional and behavioral repercussions, as well as the resultant physical injuries in older adults. New onset changes in behavior such as agitation, withdrawal from social interactions, panic attacks, or signs of unexplained fear warrant further investigation. Sometimes victims of sexual abuse can display inappropriate aggressive or unusual sexual behavior as well.[36] Depression and suicidal ideation are very common in abuse survivors and sometimes so extreme that they can lead to suicide attempts in older adult victims.[37] When evaluating for evidence of abuse it is important to consider the unseen evidence in addition to identifying the physical and chemical forensic markers of physical abuse and neglect.

IX. CONCLUSION

A multitude of interacting physical, cognitive, emotional, and social factors make older adults susceptible to abuse and

30. Patricia M. Speck et al., *Case Series of Sexual Assault in Older Persons*, 30 CLINICS GERIATRIC MED. 779 (2014); J. Mickish, *Abuse and Neglect: The Adult and Elder*, *in* ADULT PROTECTIVE SERVICE: RESEARCH AND PRACTICE 33 (Bryan Byers & James Earnest Hendricks eds., 1993).
31. Speck et al., *supra* note 30.
32. Collins, *supra* note 4.
33. Ann W. Burgess, Nancy P. Hanrahan & Timothy Baker, *Forensic Makers in Elder Female Sexual Abuse Cases*, 21 CLINICS GERIATRIC MED. 399 (2005).
34. Speck, *supra* note 30.
35. Pamela B. Teaster et al., *Sexual Abuse of Older Adults: Preliminary Findings of Cases in Virginia*, 12 J. ELDER ABUSE & NEGLECT 1 (2001).
36. Burgess et al., *supra* note 33.
37. Nancy J. Osgood & Ameda A. Manetta, *Abuse and Suicidal Issues in Older Women*, 42 OMEGA-J. DEATH & DYING 71 (2001).

neglect. Despite this complexity, it is possible to distinguish when injuries are due to abuse rather than due to benign or accidental causes. Figuring this out may require a variety of experts who are particularly knowledgeable about different aspects of the aging process. Forensic markers of abuse such as bruises, pressure sores, and fractures must be understood in the context in which they occurred. Medications may be misused in multiple ways that cause pain, suffering, and/or confusion. While abuse is categorized into specific types such as physical abuse, sexual abuse, financial abuse, neglect, etc., the reality is that polyvictimization is a common phenomenon. With the rapid growth of the aging population and the greater awareness of elder abuse as a crime, we can expect to see more cases coming through the court system. This presents an opportunity to create a more just society so that older adults may age with dignity and grace.

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