Intimate Partner Violence and Elder Abuse: The Basics

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Disclaimer: Participants must always be aware of the hazards of using limited knowledge in integrating new techniques or procedures into their practice. Only sound evidence-based dentistry should be used in patient therapy.

Conflict of Interest Disclosure Statement

- Jennifer Rudy reports no conflicts of interest associated with this course. She has no relevant financial relationships to disclose.

Short Description

This continuing education course will provide information on Domestic Violence, in particular Intimate Partner Violence (IPV) and Elder Maltreatment (EM), as well as describe victims and perpetrators, and outline the dental professionals' responsibilities to recognize, report, treat, and prevent such cases.

Dental Students: This is part 1 of a 2-part continuing education series. "*Child Maltreatment: The Role of a Dental Professional*" is the second course. For students taking these courses, both courses should be completed. As healthcare providers, you are obligated to understand these topics and report, as appropriate.

Course Contents

Overview

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Learning Objectives

Upon completion of this course, the dental professional should be able to:

- List the types and warning signs of IPV and EM.
- Explain the dental professional's obligations to identify and report IPV and EM according to state regulations.
- Describe the physical and behavioral characteristics of the victims that may appear in a dental situation.
- Identify various intervention and prevention techniques, utilizing the AVDR model.
- Explain the complexity and breadth of these problems and how they affect victims, families, and entire communities.

Introduction

Intimate Partner Violence (IPV) and Elder Maltreatment (EM) are widespread problems that affect people from all cultural and socioeconomic segments of society, but some segments of society face inequities in risk for violence. IPV includes multiple types of violence, such as physical and sexual violence, stalking, and psychological intimidation by a former or current partner.[1] The Center for Disease Control (CDC) states that millions of Americans are affected by IPV yearly, making it a very common public health problem.[1] Nearly 40% of women and approximately 26% of men reported experiencing some type of intimate partner violence in their lifetime.[2] On a typical day, domestic violence hotlines throughout the county receive nearly 20,000 calls.[3,4] Experiencing IPV can obviously result in acute health issues, but can also manifest itself into chronic health issues for the victims.[5] For older adults (over age 60), nearly 1 in 10 will experience elder abuse, neglect, or financial exploitation. That number moves to 1 in 5 if the individual has cognitive deficits.[4]

While all health professionals are legally mandated to report suspected cases of child maltreatment to the proper authorities, mandatory reporting of cases of IPV and EM may vary by state. The best practice is to understand one's local/state reporting laws, as failing to report when mandated could lead to a variety of consequences, including possible loss of license.[6] Unfortunately, dental professionals as a group have been less inclined to report IPV, especially as compared to other medical professionals[7] despite the fact that dental professionals are in a unique position to recognize head and neck injuries that are common results of IPV and EM. The dental office may be the most consistent place

a victim receives health services and a dental professional is often the most trusted health professional in a victim's life.[8] Therefore, dental professionals attuned to issues of domestic violence should be able to recognize and identify many of the warning signs of IPV and EM and ultimately help these individuals.

Definition of Intimate Partner Violence

Intimate partner violence: "willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control."[9] It occurs when such abuse is "perpetrated by one intimate partner against another" and is marked by one "partner's consistent efforts to maintain power and control over the other."[9] IPV not only occurs in a current relationship, but can also be initiated and maintained by a former intimate partner.

This control may manifest in a variety of forms, including economic and emotional abuse,[9] physical and verbal assault, threats of violence, kidnapping, harassment, criminal trespassing, or stalking.

Other Specific Definitions:

Physical Violence: As the name suggests, physical violence includes anything like slapping, pushing, shoving, hitting, kicking, beaten, burned on purpose, choking or suffocating an individual. Physical violence can also go as far as have weapons, such as knives or guns, used against the victim.[5]

Stalking: "harassing or threatening behavior that an individual engages in repeatedly that causes the victim fear or safety concern, such as sending the victim unwanted presents, following or "laying in wait" for the victim, damaging or threatening to damage the victim's property, appearing at a victim's home or place of business, defaming the victim's character or spreading rumors, or harassing the victim via the Internet by posting personal information."[10] Many advocates recognize that stalking behaviors may "[signal] particular risk, as it has been linked with repeat violence (including lethal violence), increased psychological distress and diminished physical and mental health."[11]

Sexual Violence: "forcing or attempting to force a partner to take part in any sex act, sexual touching, or a non-physical sexual event" such as sexting without consent.[2] Most people just associate the term sexual violence with rape, but it is more than as you can see from the definition above.

Psychological Aggression/Abuse: using verbal and non-verbal communication with the intent to harm a partner mentally or emotionally and/or to exert control over a partner.[2] This can include insulting or humiliating the victim, making fun of the victim in front of others, and "coercive control and entrapment, which includes behaviors that are intended to monitor, control, or threaten an intimate partner."[5] This type of abuse is directly related to eroding a victim's self-worth.

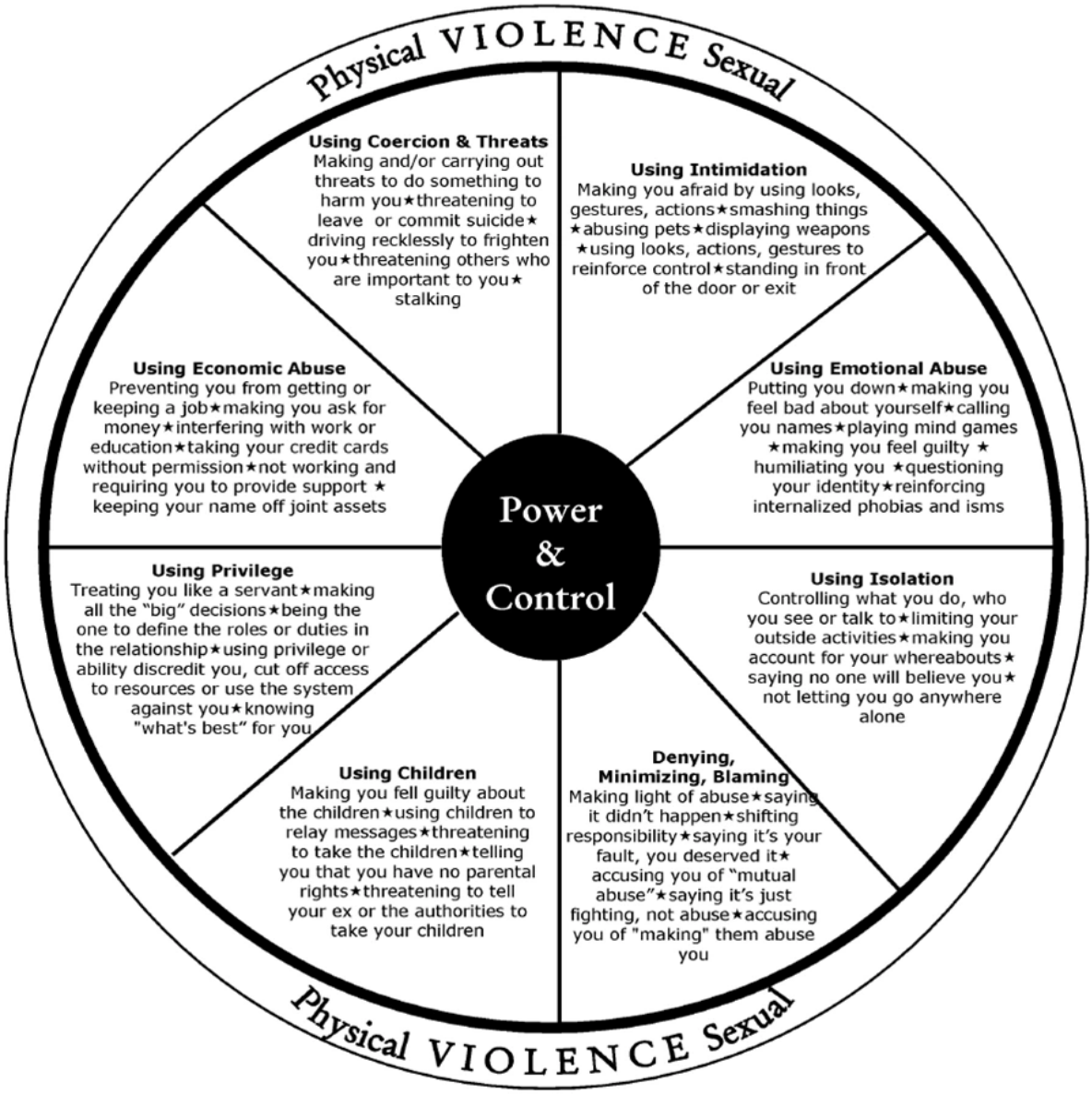
Dynamics of Power and Control

The Domestic Abuse Intervention Programs' Power and Control Wheel[12] is a common framework for understanding the dynamics between abusers and victims of intimate partner violence. This framework highlights that the foundation of abuse is due to wanting to gain absolute power and control in the relationship. It is a common tool in counseling and advocacy groups to help women identify tactics their partners have used against them. The power and control wheel also may be used in counseling services with the abusers themselves so that they can see that their behavior is not a norm and then can explore their believes that contribute to the atypical behavior. The power and control wheel highlights various aspects to IPV, some of which health care professionals may not have considered to be a part of abusive relationships. It can also provide an explanation as to why a victim may not want to reveal the abuse or proceed with either leaving or legal action against their abuser. An abusive partner may exhibit some of these patterns of behaviors but not others in order to maintain the power and control in the relationship.[12]

It is important to point out that the Duluth "Power and Control Wheel" Model was developed in 1984 as part of the Domestic Abuse Intervention Project, which was based on the experiences of women who were living with men in abusive relationships. It was not intended to reflect all types of violent relationships but "...offers a more precise explanation of the tactics men use to batter women...and reflects power imbalances in society" between men and women.[12]

An updated gender-neutral version of the wheel was created by The Blackburn Center, pointing out that IPV is not exclusive to just women, as other communities, such as males and LGBTQ to name a couple, also deal with IPV.33 It is important to note that violence in relationships in these communities occurs "within the context of larger societal oppression" and intersectionality.[12]

Figure 1. The Duluth Model.[12]



Adapted from the Domestic Abuse Intervention Project Duluth, Minnesota

Figure 2. The Blackburn Center - Power and Control Wheel.[33]

Prevalence and Incidence of Intimate Partner Violence

- About 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.[13] However, true prevalence of IPV is unknown due to victims underreporting out of fear and shame.[14]
- Women are significantly more likely than men to be injured during an intimate partner assault. On average, more than four women a day are murdered by their husbands or boyfriends in the US.[15]
- Over half of female homicide victims are killed by a current or former male intimate partner.[2] In nearly 70–80% of intimate

partner homicides, no matter which partner was killed, the man physically abused the woman before the murder.

- The lifetime prevalence (at some point in their lives) of any type of intimate partner victimization is 1 in 2 for women and 2 in 5 for men.[5]
- According to the 2016/2017 Report on Intimate Partner Violence, "almost three-quarters of female victims of intimate partner violence reported that they were first victimized before age 25, and more than 1 in 4 were first victimized before age 18.[5]
- About 75% and 48% of female and male survivors (respectively) experience some form of injury related to their abuse.[2]•
- Marginalized groups, such as racial and ethnic minority groups, are at greater risk for worse consequences of IPV.[2]
- IPV victims commonly report mental health issues like anxiety, depression, PTSD and chronic health issues associated with the heart, muscles/bones, digestive, reproductive and nervous system problems. They are also likely to engage in riskier health behaviors such as smoking, high alcohol use, and risky sexual activity.[2]
- Each year, upwards of 324,000 pregnant women in the country are battered by the intimate partners, making IPV more common that gestational diabetes or preeclampsia – conditions in which women are routinely screened.[16]
- Patients who are screened by a medical/dental professional are 2 times more likely to disclose abuse and they are 4 times more likely to seek help.[17]
- IPV related injuries, along with decreased productivity at work, and costs associated with the criminal justice system is estimated to have a lifetime economic impact of $3.6 trillion.[2]

Intimate Partner Violence for Dental Professionals

The dental community can play a vital role in identifying and halting the cycle of IPV by simply offering screening services to every single patient. However, one study of dental professionals found that "...61.5% of participants reported being unprepared to appropriately screen for IPV and 64% felt they could not correctly refer patients to local support services."[18] Not only is preparedness a barrier for screening for IPV, but some practitioners fear losing a patient because of asking "taboo" questions or a potential lawsuit, the dental health professional being uncomfortable with the topic, and, if male, assuming that patients would more likely disclose to a female practitioner.[19] However, more than half of victims surveyed in 2009 in Texas had seen a dentist when physical signs of their abuse were visible and "...more than two-thirds indicated that they would have appreciated being asked" about the etiology of their injuries.[19]

If a patient reveals being a victim of IPV, the dental professional needs to offer empathetic support and referral options. Signs of IPV may be observable physical wounds or other marks. Almost 75% of IPV victims have injuries to their head and neck regions, which is exactly the area of specialty for dental professionals.[8,19] They could also include certain types of behavior or behavioral changes. Specific signs include:

- Public and private demeaning actions by intimate partner. The partner may be reluctant to leave her or him alone during the appointment, is domineering, or answers all questions for a patient who would otherwise be capable of answering for him or herself.
- Injuries to the neck, head, and face that may be in different stages of healing including:
  - intraoral bruising, patterned bruising around the neck due to strangulation;
  - abscessed, avulsed, or non-vital teeth;
  - lacerations or burns;
  - fractures to teeth, mandible, maxilla, or nose;
  - torn frenum or mucosal linings;
  - complaints of headaches;
  - bite marks;
  - multiple injuries in various stages of healing;
- Various types of behavior changes, either observed or reported, including:
  - chronic pain or inability to sleep,
  - personality changes,

- frightened behavior when with the opposite sex,
- afraid to return home,
- report of injuries caused by intimate partner,
- drastic behavioral changes in presence of intimate partner,
- victim appears embarrassed, vague, anxious, or depressed,
- low self-esteem,
- blaming self or others for everything,
- changes in the patient's routine including patients who used to come in for regular check-ups and who suddenly stops.
- exaggerated startle response
- spontaneous tears
- dissociation from eye contact (or a sudden fading out of the patient's attention/responses to cues)
- inability of patient to talk clearly due to breathing patterns or panic
- reluctance or insecurity in answer questions posed by the dental professional

Role of Dental Professionals in Intimate Partner Violence

A majority of IPV cases (around 75%) include injuries and trauma to the neck and head. Dental professionals are in a unique position to encounter and examine such injuries.[7]

Dental professionals report a variety of barriers to intervention including:

- limited knowledge and training about IPV issues,
- lack of practical experience on how to intervene,
- misconceptions about the nature of intervention,
- fear of being sued (which when done with good intentions and "reason to believe" is not an issue),
- lack of information on resources for reporting,
- presence of others in the examination room (including the patient's partner or children),
- concerns about offending the patient, and
- embarrassment about bringing up the topic.

Trauma Informed Care

Landmark research known as the Adverse Childhood Experiences (ACE) study has shown that exposure to abuse, neglect, discrimination, violence, and other adverse experiences increase a person's lifelong potential for serious health problems. As health care providers grow aware of trauma's impact and implications of ACE studies, they are realizing the value of trauma-informed approaches to care. Trauma-informed care means taking into account a patient's life experiences so as to deliver care that may improve patient engagement, treatment adherence, and health outcomes. This approach is also designed to improve outcomes and health for providers themselves.[21]

Developing trauma-informed care skills can be an important way to better recognize and respond to patients who may be victims of violence, including IPV and EM.[21] For a survivor of sexual assault or IPV, the dental office can be a really scary place and may trigger negative responses related to the underlying experiences of abuse. Dental professionals should be aware of these possible triggers and develop techniques to incorporate into their daily practice (as described in the next section describing the AVDR method).[22]

Responsibilities and Intervention Techniques for Dental Professionals

Dental professionals must understand their obligations to report when they suspect someone may be a victim of IPV or EM. One proven approach to having this conversation is known as "ask, validate, document, and refer/report if required by law" or AVDR.[23] The AVDR model provides a framework for dental professionals responding to any kind of family violence. It also helps ensure that victims are offered resources that may be needed as well as fulfill a dental professional's legal and ethical obligations.

Before even engaging in the ADVR method, there are some baseline steps dental professionals should take to be prepared to appropriately respond to a patient reporting

or showing signs of abuse. Dental professionals should establish and maintain a professional therapeutic relationship with the patient. They should also become familiar with the signs of IPV and EM and the state reporting requirements for each type of abuse. The ADVR method includes:

- **ASK:** This includes not only actively asking questions, but also listening closely and observing suspicious evidence that can be ascertained during a dental patient's office visit (or anyone accompanying them). Be free of distractions and sit in a position that is comfortable for the patient. Ideally, it helps to ask these questions when the patient is alone with the dental professional so that they can be asked in a non-threatening and non-judgmental way. If the patient is a non-English speaking patient, use a professional interpreter instead of the person who they brought to the appointment in order to circumvent the partner trying to control the patient.[14] If the patient asks why such questions are necessary, it may help to explain that they are routine screening questions that may not appear to have a relationship with the mouth, but in actuality, they have a significant relationship with oral health.[14] Personal safety and well-being are some of those important things. If you live in a state with mandatory reporting requirements, make the patient aware of these before full disclosure. Please note that you need to be prepared to hear the patient's answers. Caring, empathetic questions may open the door for later disclosure as you build rapport. Also, refrain from using language with stigmatizing words, like "rape," "abuse," "battered," or violence" in your questions.[14]

  Sample Questions:
  - Do you feel safe at home?
  - You seem stressed and I noticed you missed your last appointment. Are you ok? Is there anything I can do to help?
  - I don't know if this is a problem for you, but many of our patients have been dealing with domestic violence, so I started to ask all my patients routinely.
  - I see that you are grinding your teeth regularly (or insert intraoral/extra oral finding). What in your life could cause that?
- V**ALIDATE:** Respond to patient's feelings and take time to acknowledge that disclosure is scary. Assure the patient that he or she is doing the right thing in telling you and acknowledge their courage to disclose such personal information. Take anything the patient reports seriously and assure patients of confidentiality to the extent allowed under the state's mandatory reporting laws. It is also important to remember that dental professionals without counseling credentials must avoid offering advice or telling the patient what to do. There are many strategies that you can practice in role-playing activities to become comfortable validating patient reports.

  Common responses could be:
  - "I am sorry you have been hurt."
  - "I am concerned about you and your safety."
  - "There are resources out there that can help you."
- **DOCUMENT:** Record or document any evidence that may be helpful, including physical evidence and any verbal comments. If at all possible, it is recommended to use direct quotes from the patient when documenting the conversation. If you report the abusive situation due to the mandatory reporting laws in your state, document a case number into your notes if the state provides one. Consider asking the patient if you can photograph visible injuries, if possible, or make sure to describe orofacial injuries in detail. It is helpful to hold something up to document the extent of the injuries (e.g., if intraoral lesions, place the probe beside it to document how big the lesion is). Finally, use neutral language in your documentation. Instead of "alleges," use the word "reports." Words that have a negative connotation can be used against the victim by the defense counsel (alleges, refuses, etc). This detailed information could be very beneficial information if the victim decides to pursue any legal action against the perpetrator.
- **REFER AND REPORT:** Treat injuries within the expertise of the office and refer to other healthcare providers for other injuries. Provide patients with options and

resources for next steps, including referrals to domestic abuse advocacy organizations. Consider having small, easy to conceal cards or other resource information already available for patients that contain information for local resources. Even having these resources available in privately accessible areas like restrooms is helpful, especially if the victim is not ready to disclose to you.[14] Developing relationships with local domestic abuse programs can help professionals in a dental office make the referral process even more effective and provide dental professionals with ongoing training. Document the referral information given to the patient and file mandatory reports if needed. Schedule a follow-up visit.[18]

Sample Documentation Language (to be used in addition to your normal dental progress notes:
Patient reports physical abuse by significant other on 8/7/22. Pt states "he pushed me up against the wall, grabbed me around the neck and punched me in the face." A contusion noted to left side of face, round, light purple in color. Intraorally, bilateral lacerations in healing stages on buccal mucosa and patient reports biting self when being grabbed. Extra and Intra-oral photographs taken after approval from patient. Referrals provided for local IPV services and patient took local shelter business card. Patient asked if she would like to report incident to police. Patient declines reporting at this time.

**Add report number if your state qualifies for mandatory reporting, such as: "*Report made to APS. Report number 65432. Patient informed of APS report.*"

Key parts: Reports *(instead of alleges),* **Declines** *(instead of refuses), and* **direct quote** *from patient.*

Legal Responsibilities

Each state generally has specific mandatory maltreatment reporting laws for children and for elders (sometimes categorized as vulnerable adults). General domestic violence reporting laws, including IPV, however, are different. These laws are not adopted in all states. "Although the intent of mandatory reporting is to identify and protect individuals before the next act of biolence, the individual's safety, in fact, may be jeopardized" and because of this, some states have eliminated mandatory reporting unless is special circumstances.[14] Depending on the state, a dental professional may have the legal responsibility to report suspected IPV no matter who the victim may be.

To learn how to report suspected IPV and mandatory reporting requirements in your state, contact your Department of Human Services in your state or your city/ county's Adult Protection Services.[24] You may also go to your state IPV/Domestic Violence Coalition site for the most up to date reporting information.

Elder Maltreatment (EM)

Dental professionals are seeing more elderly patients in their clinical practice since our population is aging due to the baby boomer generation turning 65 years old or more. The CDC defines an "older adult" as "someone age 60 or older.[25] "Many older adults require care and are vulnerable to violence perpetrated by a caregiver or by someone they trust.[23] Clinically, we are seeing a national decline in edentualism, and the geriatric patient's focus is switching to prevention of oral diseases as opposed to treatment after a problem occurs, meaning they come into the dental office more often than previous generations. This increases the likelihood that we will be seeing Elder Maltreatment/Abuse (EM) more often than in the past.

A uniform definition of EM does not exist, as states take varying approaches to define it in law. Generally, however, it is a knowing, intentional, or negligent act by a caregiver or any other person that causes harm or serious risk of harm to an older adult or vulnerable adult. This includes physical and emotional abuse, neglect, or financial exploitation. Usually the perpetrator is in a position of trust to the victim, but not necessarily in all circumstances.[26]

Prevalence and Incidence of EM

- Thousands of elderly are abused, neglected, or exploited each year, although exact

numbers remain unknown in part because of a lack of reporting. For every reported case of elder abuse, authorities estimate that approximately 24 cases go unreported.[27]

- Many elderly, especially those who depend on others to help them meet their basic needs, face maltreatment by spouses, family members, personal acquaintances, professionals in positions of trust, or opportunistic strangers who prey on the vulnerable.[28]
- Nearly 1 in 10 older adults will experience some form of abuse, neglect, or financial exploitation in their lifetime. Older adults experiencing abuse have a 300% higher risk of death compared to those who have not been mistreated.[4]
- Many cases go unreported due to fear from the elderly or being unable to communicate about the violence, neglect or exploitation.[25]
- The CDC reports that from 2002 to 2016, there were more than 643,000 older adults treated in the ER for nonfatal assaults and over 19,000 homicides occurred.[25]

Different Types of Elder Maltreatment and Accompanying Signs Dental Professionals Should Look For

In general, an elder may exhibit some signs that could signal any type of maltreatment may be occurring. Consider changes in the behavior and affect of the patient, including:[26]

- sudden change in behavior;
- withdrawn or passive behavior;
- depression, agitation or anxiety; or
- a self-report of being abused, confined or isolated, or having someone inappropriately controlling their finances.

Note that these changes can also be associated with other medical issues as well, so it is essential to take and have good comprehensive medical history. As a dental clinician, we must be able to discern normal aging processes from signs of elder abuse as well.

- **Physical maltreatment** - inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving the elder of a basic need. Signs may include:
  - bruises; lip trauma; bone fractures; broken eyeglasses or frames; fractured, loose, or unexplained missing teeth; unexplained bruises, pressure marks, bruising of eye(s), welts, lacerations, cuts, or burns.
- **Sexual maltreatment** - inflicting non-consensual sexual contact of any kind.
- **Emotional or psychological maltreatment** - inflicting mental or emotional anguish or distress on an elder person through verbal or nonverbal acts. Signs may include:
  - caregiver's refusal to allow visitors to see the elder alone,
  - consistent degrading comments or threats (including the threat of moving the elder to a nursing home or other facility), or
  - depriving the elder from going into the community.
- **Financial or material exploitation** - illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder. Signs may include:
  - report of unexpected withdrawals from financial accounts; abrupt changes in the elder's financial documents such as power of attorney forms, healthcare directives, trusts, or a will; and unpaid dental bills (especially if finances are controlled by a fiduciary such as a power of attorney or conservator).
- **Neglect** - refusal or failure by those responsible to provide food, shelter, health care, or protection to a vulnerable elder. Signs may include:
  - ill-fitting dentures, lack of dental care, and poor dental or personal hygiene; signs of being restrained; report of confinement or isolation; failure to appear at scheduled appointments; and delays in seeking care.
- **Self-neglect** - the behavior of an elderly person that threatens his/her own health or safety. Self-neglect is different from other types of neglect (i.e. caretaker neglect) because it is not attributable to another person.
- **Abandonment** - the desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.

Risk Factors of Victims and Perpetrators

Knowing the basic risk factors about who is likely to be maltreated can help dental professionals better recognize possible signs of abuse, neglect, or exploitation. Social isolation, living arrangement (living with a caregiver), and cognitive issues such as dementia, are all understood to be risk factors.[29]

Understanding who perpetrates elder abuse is also helpful to better understand the issue and possibly identify warning signs in patients. Such risk factors include diagnosis of mental illness or chemical dependency, poor or inadequate preparation or training for caregiving responsibilities, inadequate coping skills, especially in high levels of stress, exposure to abuse as a child, high financial and emotional dependence upon a vulnerable elder, current health problems, past family conflict, and lack of social support.[28] Many times, older adults depend on the perpetrator for caregiving or other needs, complicating common societal interventions such as those offered through the criminal justice system. If the older adult is in a long term care facility such as a nursing home, staffing problems and staff burnout contributes to stressful working conditions and high turnover rates. These high turnover rates can lead to hiring staff without specific qualifications or coping strategies.[25]

Interventions and Reporting Elder Maltreatment

While research on EM is still limited, it is widely understood that many older adults who are maltreated experience more than one type of abuse. The combination of emotional abuse and financial exploitation, for example, is commonly experienced among abused elders. That is why it is important to understand all types of maltreatment.[30]

In addition to the trauma-informed techniques addressed earlier, dental professionals can ask the patient three direct questions if they suspect signs of elder maltreatment are present:

- Is anyone taking your money?
- Are you afraid of anyone?
- Is anyone hurting you?[31]

In many states, adult protection or human services officials may be the initial investigators on elder maltreatment cases. Make sure to notify proper authorities, which is often the local adult protection services.[32]

Course Test Preview

To receive Continuing Education credit for this course, you must complete the online test. Please go to: *www.dentalcare.com/en-us/ce-courses/ce674/test*

1. Dental professionals are in a unique position to screen for domestic violence with their patients because about what percentage of the injuries occur in the head and neck regions?

A. 15%
B. 30%
C. 50%
D. 75%
E. 95%

2. All of the following are part of the AVDR method EXCEPT one, which is the exception?

A. listen closely and attentively to the patient
B. consider using informed trauma techniques
C. use language such as "alleges" and "refuses" in the documentation and summarize the victim's story
D. report the incident consistent with the laws of their state

3. The "Validate" part of the AVDR model is a way that we can support and encourage the victim of interpersonal violence. The Validate part of the AVDR model also encourages dental professionals to counsel the patient regarding their abusive situation and advise them to leave their relationship.

A. Both statements are true.
B. Both statements are false.
C. First statement is true, second statement is false.
D. First statement is false, second statement is true.

4. Dental professionals are the most likely of all health care professionals to intervene in cases of suspected IVP.

A. True
B. False

5. IPV can range in type and severity, but perpetrators nearly always _____ the victim.

A. commit physical abuse against
B. exert power and control over
C. commit emotional abuse against
D. sexually assault
E. use financial manipulation over

6. The general definition of EM is: any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or serious risk of harm to an older adult.

A. True
B. False

7. Many older adults may experience _____, although dental professionals _____ consider it a risk factor of maltreatment.

A. social isolation, should not
B. cognitive decline, should
C. adverse childhood experiences, should not
D. cognitive decline, should not
E. C and D

8. True or False: Dental professionals are seeing more older adults in their clinical practice and, as such, have more opportunities to come across and detect possible EM.

A. True
B. False

9. Which of the following, by itself, would not raise concerns about possible EM?

A. Lip trauma, fractured, loose, or missing teeth
B. Patient's dentures are ill fitting and dental (and personal) hygiene is poor
C. Broken eyeglasses, hearing aids, or other personal items
D. Patient is well-groomed
E. Patient reports she is missing money

10. Which of the following is true?

A. EM victims are almost always low income.
B. EM victims may often experience more than one form of maltreatment.
C. EM victims will almost always tell dental professionals without prompting that they are being abuse.
D. EM perpetrators are usually strangers.
E. EM is a serious, though not widespread, problem.

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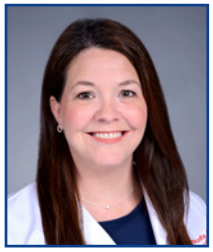
Additional Resources

- No Additional Resources Available.

About the Author



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