Elder abuse

BACKGROUND Elder abuse is a common and yet often unrecognised problem in our community. With up to 5% of the community dwelling older population being victims of abuse, the general practitioner has a pivotal role in identifying this abuse.

OBJECTIVE This article provides an outline of the definition of elder abuse, describes the types of abuse seen and the reasons for occurrence of abuse. It summarises the role of the GP in the identification and management of abuse and provides guidance on intervention strategies. Case studies are used to illustrate the issues discussed.

DISCUSSION Elder abuse is defined as any pattern of behaviour which causes physical, psychological, financial or social harm to an older person. The role of the GP in identifying abuse is critical. The vast majority of older people visit their GP at least once a year, and the GP often has a long standing relationship with their patient and the patient's family. They are therefore ideally placed to identify elder abuse.

In Australia, elder abuse was not recognised as a problem until the late 1980s, and there is still a lack of professional and public awareness of the problem. However, over the past 15 years, research throughout the country has confirmed the significance of abuse as a social, medical and legal problem in the Australian community. States have responded to this problem in different ways with funding of specific elder abuse agencies in South Australia and Queensland, development of interagency protocols and education of service providers in New South Wales and Western Australia, and publishing of a guide for health and community services in Victoria. Most agencies dealing with older people now have protocols in place for management of elder abuse.

Currently the majority of cases of elder abuse are assessed and managed by geriatric health services, and in particular aged care assessment teams (ACATs). General practitioners – and the medical profession in general – are less commonly involved. There are a number of reasons why medical practitioners have not been involved in managing cases of abuse. These include lack of awareness of the problem, discomfort at dealing with cases of abuse, lack of time, and fear of legal action.

Definition of elder abuse

It is difficult to recognise a problem if it is not adequately defined. Because ignorance or lack of understanding of the definition of elder abuse has, in the past, led to under reporting and poor recognition, it is important to have a simple, widely accepted working definition of elder abuse. The following definition has been in use among medical and allied health professions in Australia for some time[1]:

> 'Elder abuse is any pattern of behaviour which causes physical, psychological, financial or social harm to an older person'.

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The abuse occurs in the context of a relationship between the abused person and the abuser, and therefore excludes self mistreatment and self neglect from the definition. The abuse may occur in the community, in residential care, or in the hospital setting. The abuser may be a family member, friend, neighbour, paid carer or other person in close contact with the victim. Most often the abuse described will occur in people 65 years of age or over. However, abuse of vulnerable adults occurs in all age groups: a 40 year old person with multiple sclerosis may be as much at risk of abuse as an 80 year old with Parkinson disease.

Types of abuse

There are different categories of abuse, and it is important to identify the specific type of abuse as there are different contributory factors and interventions for each.

Physical abuse

Physical abuse is the infliction of physical pain or injury, or physical coercion. Examples include hitting, slapping, pushing, burning, sexual assault, inappropriate use of medication, and physical restraint. Signs include a history of unexplained accidents or injuries, bruising, burns, bite marks, abrasions, rope burns, or fractures (*Figure 1*).

Psychological abuse

Psychological abuse is the infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and feelings of shame, indignity and powerlessness. Examples include verbal intimidation, humiliation and harassment, shouting, threats of physical harm or institutionalisation, and withholding of affection. Signs include fear and anxiety, apathy, resignation, withdrawal, and avoidance of eye contact.

Case 1 – When blood is thinner than water

Mr Gray is a man in his late 70s admitted to hospital with a short history of haematemesis. He had arthritis and occasionally took anti-inflammatory drugs. Gastroscopy showed the presence of a gastric ulcer and he was commenced on treatment and discharged. He was re-admitted a month later after a massive lower bowel haemorrhage from which he almost died. On admission, his INR was elevated and he was noted to have very high levels of warfarin in his urine. His GP confirmed that he was not being prescribed this for any medical reason. As he was recovering, the patient made an off-hand comment about how his son would be glad to see the last of him. The hospital social worker investigated further and discovered that the patient's son had major financial problems. He also held power of attorney for his father. It transpired that he had mortgaged his father's home and spent most of his liquid assets, all without his father's knowledge or consent. The daughter-in-law was a nurse, who in her job, had easy access to the drug warfarin. It appeared that this man was being poisoned.

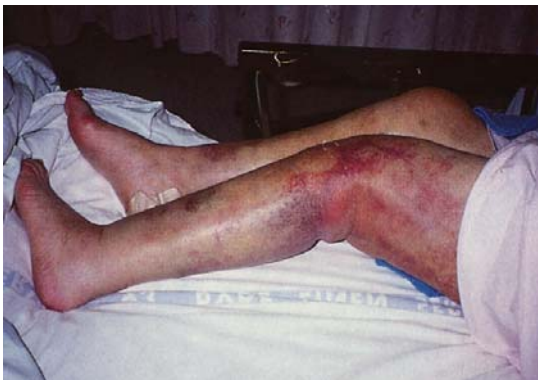

Figure 1. Injuries sustained as a result of being tied to a garden bench

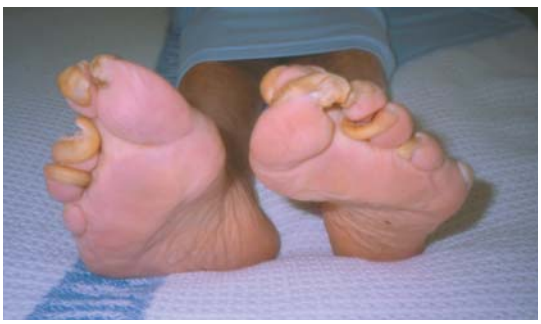

Figure 2. Overgrown toenails as an indicator of neglect

Financial or material abuse

Financial or material abuse includes the illegal or improper use of the older person's property or finances. This includes misappropriation of money, valuables or property, forced changes to a will or other legal document, and denial of the right of access to, or control over, personal funds. Signs include sudden inability to pay bills, loss of credit cards, bank books or cheque books, unexplained withdrawal of money from an account or transfer of money, and the improper use of a power of attorney.

Neglect

Neglect is the failure of a caregiver to provide the necessities of life to an older person, ie. adequate food, shelter, clothing, medical care or dental care. Neglect may involve the refusal to permit other people to provide appropriate care. Examples include abandonment, nonprovision of food, clothing or shelter, and poor hygiene or personal care (*Figure 2*). Signs include mal-

nourishment, weight loss, dehydration in the absence of an illness related cause, poor hygiene or skin care, inappropriate or soiled clothing, and lack of aids such as spectacles, dentures, hearing aids or walking frame.

Prevalence of abuse

Studies both overseas and in Australia suggest that between 4 and 10% of patients referred to aged care services are victims of abuse, while between 3 and 5% of all people aged 65 years and over and living at home suffer abuse or neglect.[2–4] There are no differences in the rates of abuse for men and women, however, the majority of victims are female due to the gender proportions among older people.

The abuser

The majority of abusers (80–90%) are close family members; either the victim's spouse, adult child or other close relation. They usually live with the victim, and may be financially dependent on the person they are abusing. Although poor financial circumstances, poverty, and lack of resources may play a part in the occurrence of abuse, it is seen in all social and economic groups, in urban and rural settings, and in all religious and racial groups.

Assessment of risk

Screening is becoming an important and accepted part of medical management and is now commonplace for diseases such as diabetes, hypertension and hyperlipidaemia. With community prevalence studies indicating that between 3 and 5% of people over 65 years of age are victims of elder abuse, and the association between elder abuse and increased morbidity and mortality,[5] it is important that the medical profession consider asking about abuse in their older patients, and also look for risk factors of abuse.

Research and clinical experience show very clearly that there are a number of factors contributing to the occurrence of abuse, and a combination of these factors are usually involved in abusive situations.[6] The following risk factors are often easier to identify in the primary care situation.

Increased dependency of the older person

Older people are more vulnerable to abuse when they are helpless or dependent on others for assistance. This dependency may be due to physical impairments such as Parkinson disease or stroke, or cognitive impairments such as dementia.

Case history 2 – When all is not as it seems

Mrs White, 73 years of age, is a woman with early dementia referred to the geriatric health service as a case of physical abuse at the hands of her daughter who had moved in with her some months earlier. She had quite severe bruising on one side of her face and on her arms and lower legs. Neighbours had also reported frequently hearing loud voices. It appeared to be an abusive situation, although both the older woman and her daughter denied it vehemently. Mrs White was admitted to hospital as she was considered to be at risk. Investigations showed she had a clotting disorder resulting in spontaneous bruising. She was also noted to be quite deaf without her hearing aid and needed to be spoken to in a loud voice. Once her clotting disorder was treated and a functioning hearing aid was purchased, there were no further 'signs' of abuse.

Abuser psychopathology

The personality characteristics of the abuser are a major factor in the occurrence of abuse. Alcoholism, drug abuse, psychiatric illness and cognitive impairment or dementia in the abuser are highly significant as contributory factors in cases of abuse. In many cases of physical and psychological abuse, abuser psy-

Case 3 – When carers are abused

Mr and Mrs Jones had been married for 45 years when Mr Jones developed Parkinson disease and dementia. Despite Mrs Jones' general poor health and increasing frailty, she continued to provide all care for her husband. He refused to allow the home nursing service to assist in showering him until his wife fell in the shower and broke her wrist. When the visiting nurse attempted to shower him, he grabbed at her breasts and made suggestive comments. A male nurse took over care and no similar behaviour occurred. Once his wife's wrist fracture was healed, Mr Jones insisted that his wife shower him. The male nurse continued to visit to supervise medication and noted that Mrs Jones often had bruising on her face. She explained that she had hit her head on the door during the night, or had fallen against a piece of furniture. Eventually she admitted that her husband had got angry with her and occasionally hit her. She felt that it was her fault as she must have provoked him. The nurse spoke with their GP who visited and examined Mrs Jones. He noted bruising of different ages on her face, trunk and arms. A referral was made to the ACAT who arranged regular in-home respite for Mrs Jones, as well as assistance with showering for Mr Jones. Mrs Jones underwent considerable counselling to help her to deal with the culmination of many years of low grade domestic violence. Eventually Mr Jones required nursing home placement. Mrs Jones' health improved markedly and she became very active in a local handcraft group.

chopathology is implicated as the major contributory factor. In cases of carer abuse where carers are abused by the people for whom they are caring, dementia or psychiatric illness is frequently present in the abuser. A large number of carers of people with dementia experience aggression from the person they are caring for at some stage in the illness.

Family dynamics

In some families, violence is considered the normal reaction to stress, and this may continue from generation to generation. In some cases, the abuser was abused as a child by the person they are now abusing. Marital conflict resulting in spouse abuse can continue into old age, and in many cases of elder abuse there has been a long, past history of domestic violence. When two or more generations live together, intergenerational conflict can occur due to different values and expectations.

Carer stress

The responsibility for providing physical, emotional and financial support to a dependent older family member can generate great stress. Illness in the carer, financial difficulties, inadequate support and lack of recognition for the caring role, and personal stress can all contribute to this stress. In many cases, other contributory factors are already present and this additional stress on the carer appears to be the factor that triggers the abuse.

Older population

It is very important that these contributory factors are

Table 1. Interventions in elder abuse

Medical problems

Address underlying medical problems in both the victim and abuser. Major risk factors for abuse are the dependency of the older person due to physical or cognitive impairment and psychopathology in the abuser. Reducing symptoms of disease, improving physical function, and treating psychiatric illness or substance abuse are important ways to improve a potential or actual abusive situation

Separation

Separate victim and abuser in cases of severe physical abuse. This may require admission to an acute hospital bed

Community services

Home nursing, housekeeping help, continence advice, community options or linkages programs, and meals on wheels can be used to alleviate situations where abuse is occurring

Respite

In home respite, day centre respite, or institutional respite is particularly helpful where carer stress is a problem, and where there has been a situation of neglect. If the victim is quite dependent, often respite care in a nursing home is the only alternative

Counselling

Individual counselling or family therapy aims to help the victim cope with their situation and assist them to find a way to be safe from their abuser. In cases where domestic violence is the main cause of abuse, a referral may need to be made to the appropriate services for victims of domestic violence. These services include counselling, dedicated police officers with specific training in domestic violence, and access to a refuge. Unfortunately most domestic violence services are orientated toward younger women and many are unsuitable for the frail or disabled older person

Treatment needs of the abuser

In cases where abuser psychopathology is a major causative factor, admission to hospital may be necessary to address the psychiatric illness or drug or alcohol problems. Psychological counselling which allows the abuser to talk openly about their behaviour may be beneficial

Alternative accommodation

Institutionalise – often nursing home placement – the victim of abuse. In some situations where carer abuse has occurred, it is the abuser who requires nursing home placement

Legal interventions

May be the first line of intervention where criminal charges need to be laid in cases of financial abuse or severe physical abuse (particularly where there is a history of domestic violence). Older people who are competent to make their own decisions can, with support if necessary, access mainstream legal services such as power of attorney to evict an unwelcome person from their home. Chamber magistrates or the police may need to be involved if an Apprehended Violence Order or restraining order is sought. Applications to a guardianship board or tribunal can be made where victims are unable to make a decision for themselves

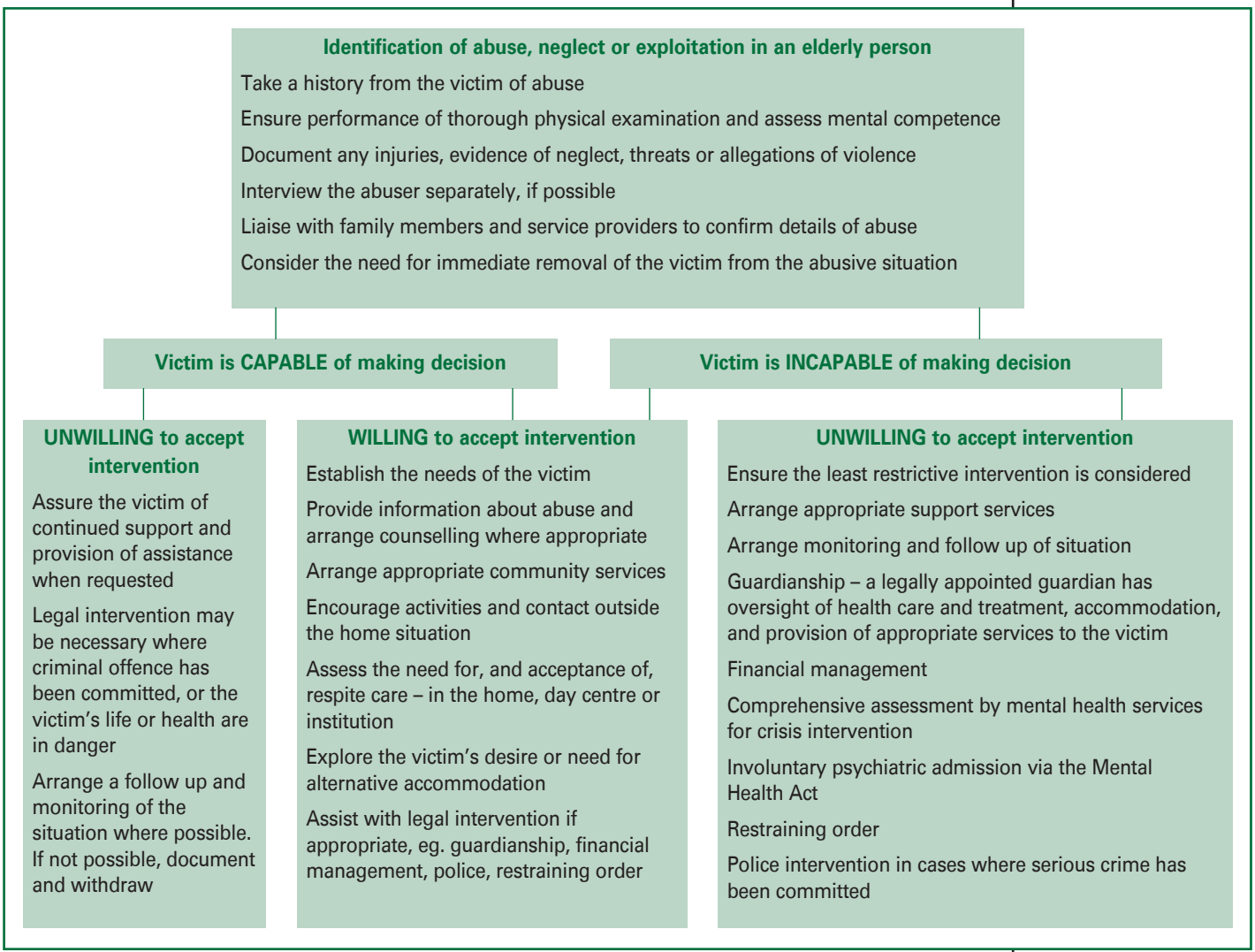

Figure 3. Strategies for intervention and management of elder abuse

looked at in the context of a population where an increasing proportion are elderly and there is an increasing prevalence of age related diseases such as dementia. Government policies are advocating community care – and in light of the limited available resources – are possibly placing extra strain on family carers.

The assessment process

Ethical principles for assessment

It is necessary to gain the consent of the patient for any assessment, and while the patient may be happy to be interviewed and examined, there are often situations where the victim does not wish any further action to be taken. Older people may be reluctant to report abuse by a family member or care giver on whom they rely for their basic needs. There may be shame where a close family member is the abuser, or there may be fear of retaliation, or institutionalisation.

It is important to take a nonjudgmental approach to cases of abuse, and often it is more appropriate to look at the situation as one in which there are two victims, rather than a victim and an abuser. Attention must be paid to resolving the unmet needs of both the victim and abuser, rather than simply identifying abuse and punishing the guilty party.

The principles of beneficence and autonomy should be observed. Beneficence is the principle of doing good and ensuring that the best interests of the patient are promoted. Harming or destroying a fragile family relationship that is important to the older person in the process of dealing with an abusive situation is not observing this principle. Autonomy is the principle of freedom of choice, and there are often major dilemmas involving duty of care associated with the principle of

beneficence and the victim's autonomy when a victim in a situation of abuse, and clearly at risk, wishes to stay in that situation. If that person is competent to make that decision, then that is their right.

Confidentiality refers to the obligation of nondisclosure by medical professionals of personal information unless they have the consent of the patient. While this is a basic tenet of medical practice, there are times when practitioners have to disclose information and so the principle of confidentiality is overridden. This occurs where there is a subpoena, where the medical practitioner believes that a crime has been committed, or where it is in the individual's interest, for example, if the individual is suicidal. Here the principle of beneficence might take precedence over confidentiality.

The role of the GP

The role of the GP in identifying abuse is critical. The vast majority of older people visit their GP at least once a year, and the GP often has a long standing relationship with their patient and the patient's family, and knows their background. Also, the GP should have detailed medical records for the patient and be well aware of both present and past medical problems, current medication and the patient's social situation. They are therefore ideally placed to identify elder abuse. The 75+ health assessment item for the over 75s was introduced into the Medical Benefits Schedule in November 1999. This item includes functional, psychological and cognitive assessments allowing the GP to have a better understanding of their patient's needs. The screening for, and identification of, elder abuse should be part of this process.

The role of the GP in managing the abusive situation is a little less clear. While management of any medical problem is clearly the task of the GP, areas such as counselling, arranging community services, applying for guardianship or organising alternative accommodation may be more appropriately dealt with by multidisciplinary staff with a geriatric health service. This also allows the GP to maintain a relationship with both parties in the abusive situation, and to remain in the role of a trusted counsellor and perhaps friend.

Management of abuse

The management of elder abuse may require the involvement of number of individuals or service providers. Ideally interventions seek to achieve freedom, safety, least disruption of lifestyle, and the least restrictive care alternatives. Victims may be unwilling to accept suggested interventions, and if they are competent to make decisions concerning these services then their decision must be respected. *Figure 3* summarises management options. Interventions are listed in *Table 1*.

Conclusion

As the number of dependent older people in the community increase, we can expect to see more cases of abuse. To date, there has been a general reluctance among the medical profession to become involved with elder abuse to the same degree as with child abuse. This is disappointing when one considers the significant contribution made in the arena of child abuse where physicians have been in the forefront of research and practice. There is a great deal that the medical profession can offer in the identification, assessment and management of elder abuse – and the role of the GP is pivotal.[1]

Summary of important points

- Elder abuse is defined as any pattern of behaviour that causes physical, psychological, financial or social harm to an older person.
- Elder abuse occurs in up to 5% of the community dwelling population aged over 65 years.
- Interventions for elder abuse may include management of medical problems, separation of victim and abuser, provision of community services, respite care, counselling and legal interventions.

Conflict of interest: none declared.

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