# Is she being abused or 'acting out'?

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Ms. L says her caretaker is beating her, but the allegation may be suspect. How can you find out the truth and ensure the patient's safety?



## HISTORY 'Unusual behavior'

Ms. L, age 44, has severe cerebral palsy and has used a wheelchair since childhood. Her mother, who had been her primary caretaker, died 12 years ago, and her stepsister has been caring for her since.

Ms. L's primary care physician reports that the patient has been "acting out" lately and asks us to evaluate her "unusual behavior." Six months ago, the physician prescribed escitalopram, 30 mg/d, to treat depressive symptoms stemming from her chronic neurologic disorder.

We interview Ms. L and her stepsister together. The patient says she has been depressed, irritable, and moody, and her stepsister confirms this. The patient shows no signs of distress during the interview, and her answers appear short and guarded.

The stepsister says she typically spends her day turning Ms. L to prevent bedsores, feeding and bathing her, replacing her urinary catheter and emptying her urinary bag, and helping her to the bathroom. At day's end, the stepsister has little time to spend with her husband or for other activities. She says at times she resents tending to Ms. L's constant needs and feels "stressed out."

Dr. Musgrove is a fourth-year resident, Dr. Turnipseed is a second-year resident, and Dr. Magid is assistant professor, department of psychiatry, University of Texas Medical Branch, Austin.

We diagnose Ms. L with a mood disorder caused by a general medical condition. We continue escitalopram, 30 mg/d, and add oxcarbazepine, 150 mg bid, to treat her irritability and lability.

## FOLLOW-UP 'She's abusing me'

At Ms. L's follow-up visit 2 weeks later, we ask her stepsister to leave the examination room and interview the patient alone to gauge her emotional condition and insight.

Seconds later, Ms. L starts crying hysterically, then reports that for 12 years her stepsister has been beating her, usually after she requests something. Yesterday, she says, her stepsister started punching her after she asked to be taken to the park.

Ms. L says the abuse is escalating and now occurs daily. She says she is covered with bruises from the last beating, although no bruises are visible at first glance. Afraid to go home with her stepsister, she pleads for help.

**At this point, I would:**

a) call the primary care physician for collateral information
b) examine Ms. L for bruises
c) get the stepsister's side of the story
d) contact state protective services
e) all of the above

## The authors' observations

Is Ms. L being physically abused, or is a psychiatric condition driving her to fabricate these allegations?

We saw nothing suspicious during the first interview with the stepsister, although she acknowledged difficulty coping with Ms. L's constant requests (***Box 1***).[1] Caring for a severely disabled person day in and day out can be trying for both the caregiver and her family, and the stepsister could be taking her frustrations out on Ms. L.

Until proven otherwise, we must assume Ms. L is being harmed and seek more information. We also must watch for signs of a delusional or factitious disorder or malingering—any of which would suggest the allegations are false.

## HISTORY A second opinion

We ask Ms. L if we can discuss the allegations with her and her stepsister, but she fears retaliation and insists that we not speak to the caretaker.

We then call Ms. L's primary care physician, who has been managing her care for several years. He says the patient has begged him numerous times for protection from her stepsister, but adds he has found no evidence of abuse. He notes that he has witnessed tension between the 2 women during office visits and cannot dismiss the possibility of abuse.

The attending psychiatrist performs a brief physical exam with the resident looking on but finds no bruises, excoriations, or unusual scarring on her arms and legs. Because our outpatient clinic lacks an examination room, we do not perform a whole-body exam.

We then notify state protective services. There, an agent tells us that in the past year, Ms. L has made 4 allegations of caretaker abuse, none of which were substantiated after extensive investigation. The agent says her office will assign a case worker but considers the case a low priority.

When we inform Ms. L of our findings, she frantically insists that her caretaker is beating her once a week and that the abuse has gone undetected. We become skeptical, recalling that Ms. L earlier said the beatings were daily.

Ms. L says she is afraid to go home and wonders where she can stay. Having no friends or other family members nearby, she requests hospitalization.

**Box 1**

### An abuser of a vulnerable adult ...

**Is often** a family member

**Experiences stress** brought on by the strain of caregiving coupled with marital problems, lack of money, overcrowded living conditions, or lack of needed health or social services

**Often abuses** alcohol and/or drugs

**Might have** emotional problems:

- Caregiver often resents patient's dependency
- If patient is caregiver's parent, caregiver might be retaliating for past mistreatment

**Depends on vulnerable adult** for basic needs such as money or housing

**Might come from a family** where abusive behavior is normal

**Source:** Reference 1

**At this point, I would:**

a) discharge Ms. L to a safe house with close follow-up
b) hospitalize her for safety and diagnostic clarification
c) discharge her to her stepsister with close follow-up

## The authors' observations

Ms. L's allegations pose a medical, ethical, and legal challenge. Physical examination and input from a protective services officer suggest Ms. L is fabricating the allegations. On the other hand, if the accusations are true, sending Ms. L home with her stepsister would endanger her.

We could hospitalize the patient and substantiate the allegations later, but we

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### Clinical Point

**Injuries from abuse can escape detection in an outpatient clinic, where whole-body examinations generally are not performed**

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**Box 2**

## Online help for caregivers

- **Caregiver.com (online magazine)**
  www.caregiver.com
- **Caring Today**
  www.caringtoday.com
- **National Alliance for Caregiving**
  www.caregiving.org
- **National Alliance on Mental Illness**
  www.nami.org (Click on "Find Support," then "Education, Training, and Peer Support Programs")

**Clinical Point**

**Report abuse after the patient provides informed consent, but be sure the patient is willing to file a report**

cannot justify taxing limited hospital resources when the need is questionable. We cannot send her to a safe house because of her severe physical disability, nor can we discuss the allegations with her stepsister because Ms. L instructed us not to.

## DISPOSITION Going home

After meeting with hospital officials and clinic staff, we decide that Ms. L does not meet admission criteria. We discharge her to her stepsister and see the patient again the next day.

### The authors' observations

**Legal duty.** Our legal duty to protect a suspected abuse victim depends on the jurisdiction in which treatment is delivered.

Texas law, for example, requires health care providers to report suspected abuse of a "vulnerable adult."[2] Failure to do so is considered a misdemeanor. If the report is made in good faith, the physician is immune from civil and criminal liability, even if the allegations are proven false.[2]

Many states do not require physicians to report suspected abuse, but this complicates the decision process. If the suspicion is correct, not reporting it might constitute malpractice or negligence and could provoke future lawsuits or complaints to the state medical board. Worse, the abuse may escalate and cause irreparable harm to the patient. Conversely, reporting unfounded suspicions of abuse can destroy the doctor-patient relationship, prompt the caregiver to retaliate against the patient, or inspire patients or caregivers to sue the physician.

If you suspect patient abuse and your state mandates reporting, contact the state protective services agency at once (see ***Related Resources, page 88***). Base your report on a thorough history and physical, psychiatric evaluation, and—when available—collateral information.

If your state does not mandate reporting, obtain the patient's consent to file a complaint with state protective services. By providing informed consent, the patient gives permission to disclose protected health information, and confidentiality is not breached.

Be careful when obtaining informed consent, especially when the patient is ambivalent about reporting because of:

- fear of retaliation from the abuser
- fear of the social stigma associated with abuse
- or the patient's false belief that she deserves the abuse.

The level of suspicion needed to justify reporting suspected abuse cannot be quantified and depends on the allegation's severity and your clinical judgment. Also, what constitutes a "vulnerable adult" varies from state to state. Knowing your state's laws and consulting with legal counsel are critical in difficult cases.

**Ethical responsibility.** Even if our legal responsibility is minimal, we should go further to do what is best for the patient.

Texas, for example, does not require physicians to hospitalize or find a safe environment for a suspected abuse victim.[2] But if you see evidence of abuse, notify authorities and offer the patient information about local safe houses, support groups, and social services—even if not mandated by law. If resources are available, consider hospitalizing the patient and work with his

or her social worker, therapist, or clergy to orchestrate outpatient services.

While treating a suspected abuse victim, consider consulting the caretaker if the patient agrees to the caretaker's involvement. Caretakers can help you gather collateral information, plan treatment, and assist with psychoeducation. Also steer "stressed-out" caretakers toward a support group or online resource (***Box 2***).

Whether or not abuse has occurred, empathizing with the caretaker about the difficulty of caring for the patient could diminish the caretaker's stress and reduce the risk of abuse.

## FOLLOW-UP Truth or delusion?

At her appointment the next day, Ms. L says things are fine at home and does not bring up the abuse allegations. We then see her every 3 days for 2 weeks, weekly for 4 weeks, and every 3 weeks thereafter as the apparent risk of abuse diminishes. At each visit, she says her caretaker is not beating her but occasionally complains that she is verbally abusive.

Three weeks after her first follow-up, Ms. L enters the examination room agitated and frightened; she says another patient in the waiting room has just tried to strangle her for no apparent reason. Upon questioning, office staff say they saw no attack and note that the accused patient is a feeble woman with no history of violence; we doubt she assaulted Ms. L.

**Ms. L suffers from:**

a) repeated physical abuse
b) delusional disorder
c) factitious disorder
d) malingering

### The authors' observations

Although Ms. L clearly was not assaulted in the waiting room, this complaint is key to understanding her case. Although whether she is being abused at home remains unclear, evidence increasingly suggests that she suffers from delusions.

Delusions are beliefs that are fixed, false, and not ordinarily accepted by others in a patient's culture or subculture.[3] Delusional disorder is characterized by nonbizarre delusions lasting >1 month (>3 months according to ICD-10 criteria)[4] with relatively preserved functioning and without prominent hallucinations. DSM-IV-TR defines bizarre delusions as "clearly implausible, not understandable, and not derived from ordinary life experience."[4,5]

Ms. L most likely has a paranoid or persecutory type delusional disorder in which she is convinced she is being harmed. Her delusional thoughts might yield mood symptoms such as anger and irritability, and she might become assaultive. Often, such patients are extraordinarily determined to succeed against "the conspirators" and frequently appeal to the legal system or law enforcement.[3]

Differentiating between a patient's delusions and reality can be difficult, leading clinicians to seek collateral information from family, past medical records, or providers to establish a diagnosis. The delusions might become less circumscribed over time, or additional information might clear the clinical picture.

Ms. L's psychological makeup might help us rule out other diagnoses. Her request for hospitalization, for example, could suggest factitious illness, but she is disabled enough to play the sick role without manufacturing symptoms. Also, she seeks hospitalization because she has no family or friends to turn to. We rule out malingering because Ms. L has nothing to gain by accusing a stranger of choking her in the waiting room.

## Treating delusional disorder

Pharmacotherapy and psychotherapy typically are used together to treat delusional disorder.

**Pharmacotherapy.** Antipsychotics such as olanzapine, 5 to 10 mg nightly, or risperidone, 1 to 2 mg nightly, can decrease

### Clinical Point

**Caregivers can help you plan a disabled patient's treatment, offer collateral information, and help with psychoeducation**

## Clinical Point

**Concomitant antipsychotics and psychotherapy can help treat delusions. Add an antidepressant if anxiety or depression develops**

the delusional thoughts' intensity and frequency, allowing patients to function more appropriately.[3] If 2 or more antipsychotic trials do not control delusional thoughts, consider starting clozapine at 300 mg/d and titrating to 900 mg/d.

Add an antidepressant if delusional thinking causes depression or anxiety. Selective serotonin reuptake inhibitors (SSRIs) such as paroxetine, 10 to 20 mg/d, or fluoxetine, 20 to 40 mg/d, are a good starting point. Consider other antidepressant types if SSRIs do not work.

Adjunctive benzodiazepines such as clonazepam, 1 to 2 mg/d, or lorazepam, 1 to 2 mg bid as needed, can help manage acute anxiety or agitation stemming from delusions.

**Psychotherapy.** Supportive therapy can alleviate anxiety and depression that often result from delusional thinking. Cognitive-behavioral therapy can teach patients to stop acting on their delusions.

Once rapport is established, consider challenging delusional beliefs by having the patient list evidence supporting or refuting the delusions. Be careful not to confront delusional thinking too quickly or aggressively, as this approach often does not change the patient's beliefs and weakens the therapeutic alliance.[3]

### TREATMENT Fewer complaints

We still see Ms. L every 3 weeks for supportive psychotherapy and medication management. We continue oxcarbazepine, 150 mg bid, and escitalopram, 30 mg/d, and add risperidone, 1 mg at bedtime, to target her delusional thinking, lability, and irritability.

Over 6 months, Ms. L's complaints of abuse become less emphatic. She endorses the abuse less frequently—every 3 to 4 visits—and only if the clinician specifically asks about it. Most often, she denies abuse is occurring but says it happened previously. At each visit, we document her statements and explain in her chart why we have not notified adult protective services or police.

## Related Resources

- National Adult Protective Services Association. Links to adult protection agencies nationwide. www.apsnetwork.org.
- National Center on Elder Abuse. www.elderabusecenter.org.

### Drug Brand Names

Clonazepam • Klonopin
Clozapine • Clozaril
Escitalopram • Lexapro
Fluoxetine • Prozac
Lorazepam • Ativan
Olanzapine • Zyprexa
Oxcarbazepine • Trileptal
Paroxetine • Paxil
Risperidone • Risperdal

### Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.


### References

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# Bottom Line

Know your state's legal requirements for reporting suspected abuse of a vulnerable adult. Guard against liability by carefully documenting evidence that supports or refutes accusations. If allegations are unsubstantiated, interview the patient, watch for signs of delusional or factitious disorder or malingering, and treat accordingly.