Elder Abuse and Utilization of Support Services for Elderly Patients

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DR. JEFFREY TRILLING (*Assistant Professor, Department of Family Medicine*): Patient denial and hidden complaints are frustrating obstacles to overcome in our attempts at patient advocacy. The family physician's roles of advisor, educator, and facilitator while applying anticipatory guidance to normal life crisis are crucial for the successful treatment and prevention of family dysfunction and illness.[1] The abused, yet denying, elderly patient is a particular challenge. In abuse cases, it is important for us not only to utilize our clinical skills for diagnosis and treatment, but also to investigate and understand family dynamics. After abuse is diagnosed and its etiology unraveled, physicians have an additional task in regard to the use of ancillary health services for the treatment of the family dysfunction. The appropriate channeling of social resources can resolve a therapeutic dilemma, as this case demonstrates. Dr. Louis Greenblatt will present the case.

DR. LOUIS GREENBLATT (*Chief Resident, Department of Family Medicine*): Mrs. C. and her family were not patients at the Family Practice Center but came to our emergency room on the day of her first University Hospital at Stony Brook admission. Mrs. C. is a 65-year-old, bilingual, Hispanic woman who complained of right ear pain and right rib pains after "falling into a parked car" near her home three days prior to admission. She denied palpitations, seizure activity, dizziness, or syncope. She also reported injuring her upper lip two weeks earlier from falling into a door. Her past medical history revealed seven hospitalizations at another institution over a five-year period for repeated falls with resultant contusions of the face, head, orbit, upper lip, right maxilla, and several lacerations of the face and forearm. The patient freely admitted to previous admissions to another hospital, but their number was unknown until we contacted the other institution. Additional traumatic history included a burn of the right breast, perinephric hematoma, and concussion. She had been seen once in our hospital emergency room three years ago for a contusion of the left zygoma after "falling into a car." Her medical history includes asthma, hypertension, and congestive heart failure. Surgical history is significant for a total abdominal hysterectomy 25 years ago for fibroid tumors. Current medications include theophylline 200 mg every 8 hours, metaproterenol inhaler, digoxin 0.125 mg daily, furosemide 20 mg daily, methyldopa 500 mg every 6 hours, and clonidine 0.1 mg twice daily. Her physical examination revealed large ecchymoses covering both breasts, the anterior chest wall, and the entire abdomen. She had old abrasions of both anterior shins, and bilateral cauliflower ears with a large hematoma on the right that was draining serosanguinous fluid. There was an upper lip laceration extending through to the mucosa, and bilateral hematomas of the posterior thoracic wall the size of large breasts. Her stools were guaiac negative, hematocrit 20 percent, and hemoglobin 6.3 g/dL with normal clotting studies. The patient was admitted and transfused with two units of packed red blood cells. Given this history and physical examination, what would your next steps be?

FIRST-YEAR RESIDENT: I would order a liver-spleen scan to rule out laceration or hematoma. Additionally, I would place the patient on a Holter monitor to rule out dysrhythmias or blocks as the cause of the patient's falls. An electroencephalogram is also indicated.

DR. GREENBLATT: These were all performed and found to be within normal limits.

SECOND-YEAR RESIDENT: The description of the patient's injuries do not sound compatible with a simple fall. This and her history of repeated trauma are strongly suggestive of abuse. Was the patient questioned along these lines?

DR. GREENBLATT: Yes. The patient denied any abuse. During the entire hospital stay she was repeatedly asked whether she had been abused and was reassured she could confide in us. Her past history, physical ex-

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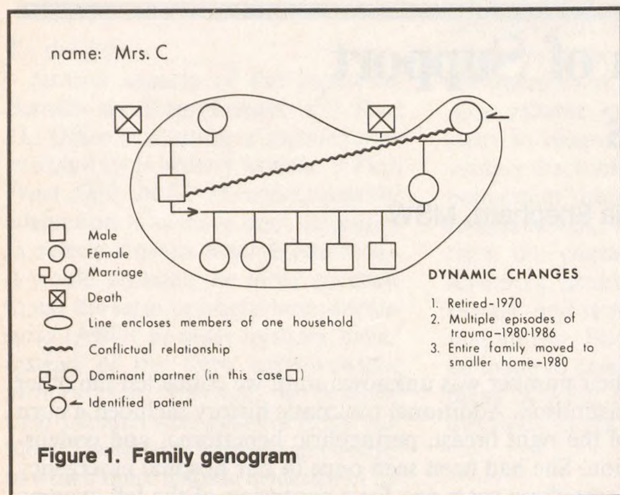

Figure 1. Family genogram

amination, and social history made abuse our primary concern, and we contacted Adult Protective Services (APS) only to find they had investigated the family on three occasions. Unfortunately, without patient cooperation they could go no further. During her current admission, it had been noted by nurses that the patient cried after receiving telephone calls from the family; however, she refused to confide in anyone. Additionally, the patient's ambivalence about discharge was obvious. Early in her hospital course, when nonambulatory, she expressed a strong desire to go home. When she became medically stable and ambulatory, discharge plans were discussed with her. The patient suddenly had exacerbations of asthma and chest pains that required workup to assure both the patient and the physicians of their functional nature.

DR. TRILLING: I think most of us find uncooperative patients exasperating, but it is important to recognize this patient's lack of cooperation as a symptom. It is easier to remain nonjudgmental and objective if we use the biopsychosocial approach to understand this patient's behavior. By visualizing the uncooperative patient as a victim of his or her family, it is possible to empathize with the helpless patient. In the typical setting, the use of the genogram is a useful tool to record both genetic and interpersonal family household data (Figure 1).[2]

It is a difficult task to assemble an abuse history in the face of patient resistance. Ms. Cynthia Shephard was asked to investigate the social issues.

MS. CYNTHIA SHEPHARD (*Social Worker, Department of Family Medicine*): I was able to obtain only scant information from this patient and her son-in-law. Engaging the patient in conversation was very difficult, as she tended to be monosyllabic and somewhat flat in affect when responding. She was pleasant, but volunteered no information, and she often complained of physical discomfort and appeared to be short of breath when I talked with her at length.

She resides with her daughter (an only child), her son-in-law (Mr. B.), and their five children, who range in age from 3 years to 13 years. Her son-in-law's mother also shares the three-bedroom house. The patient has lived with her daughter for 15 years. The family moved to this house six years ago from a larger home, which Mr. B. lost after losing his job after his employer discovered Mr. B. had a criminal record dating back to his teenage years. Mr. B. is now a house husband; his wife is employed full time as a quality control inspector. He says she makes $30,000 per year. Mrs. C., the patient, receives monthly $331 from Social Security, $37 from public assistance, and $44 in food stamps. She has a Medicaid card.

Until 1970, Mrs. C. worked as an aide in a nursing home. The son-in-law says he and the patient's daughter insisted that Mrs. C. stop working because they believed that she was being exploited on her job. Mr. B. then tried to obtain disability for Mrs. C. but was unsuccessful. He has also tried to obtain disability for himself on the basis of hypertension, but again was unsuccessful.

Mrs. C. recalls little of such specific details as when she married, where she lived in the city, when she moved to Long Island, when she was hospitalized, or what medications she is taking. Her son-in-law, while more verbal, is very vague. The patient's daughter was not interviewed; she was unavailable because she works days. Attempts to interview her at work or after hours were countered with excuses.

Mr. B. reported that the patient has a history of falling and that she bruises easily. He steadfastly denied that he or any member of his family has ever physically abused the patient. When the family was observed together by the Adult Protective Services worker in the home, family behavior seemed normal. The patient did not appear to be fearful or reluctant to answer questions, did not refer to the daughter or son-in-law before answering questions, and always affirmed that her family cares about her and loves her. Mrs. C. has never expressed any desire to leave her home to live elsewhere. She was questioned specifically regarding abuse.

DR. TRILLING: Before we can diagnose elder abuse, we must have a working definition. The Elder Abuse Prevention, Identification and Treatment Act of 1985 (H.R. 1674) defines abuse as

> . . . the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish; or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish, or mental illness; the term 'exploitation' means the illegal or improper act or process of

continued on page 584

continued from page 582

a caretaker using the resources of an elder for monetary or personal benefit, profit, or gain; the term 'neglect' means the failure to provide . . . the goods or services which are necessary to avoid physical harm, mental anguish or mental illness or the failure of a caregiver to provide such goods or services; and the term 'physical harm' means bodily pain, injury, impairment, or disease.

Kimsey et al[3] describe four categories of abuse: physical, psychologic, material, and fiscal. Physical abuse may be direct in the form of bruises, burns, rape, or fractures[4] or as physical neglect[5] (eg, failure to turn the patient often enough to prevent decubitus ulcers; tight physical restraints, etc). Psychologic abuse may take the form of benign neglect, such as in grooming and hygiene,[4] and environmental deprivation.[6] Material abuse implies theft of the material possessions of the elderly. Finally, fiscal abuse takes the form of embezzlement or fraud. Findings from a two-year study by the University of Maryland Center on Aging[7] and a survey by Hickey and Douglass[8] indicate that neglect of a passive nature (inattention or isolation) is the most common form of elder abuse. Verbal and emotional abuse, financial exploitation, and physical abuse are less common.[3]

When there is physical abuse, the patient may first present to the emergency room. The pattern of injuries may make one suspicious of abuse. The pediatric literature abounds with articles that detail estimation of age and source of contusions,[9] patterns of skin injury,[10,11] and radiographic findings[12] in abused children. The literature is sparse, however, regarding physical indicators of elder abuse, but bruises, welts on the shoulders, back, chest, or arms in various stages of healing, rope burns around the wrists or ankles, scalp hemorrhages, and multiple fractures of the long bones or ribs are signs of purposeful injury.[13] Victims of elder abuse most frequently present to their physicians with complaints of a medical problem.[14] It can, at first, be difficult to distinguish the dehydration weight loss and decubiti of willful neglect from organic disease, particularly in confused and immobile patients who have tendencies toward malnutrition.[13]

Keeping in mind a patient profile of the common characteristics of the abused elder may be helpful in raising our index of suspicion and, thereby, increase our yield of diagnoses. A review of five studies that each describe ten or more areas of elder abuse[7,15–18] basically agree that victims are predominantly old (over 75) and female, and that in over 60 percent of the case reports, the elderly person is a significant source of stress to the abuser. In 75 percent of these cases, the abuser has additional significant stresses, such as alcoholism, chronic medical problems, or financial crisis. The victim may be functionally dependent because of inadequate resources or physical limitations, and there often is a history of inter- and intragenerational conflict and previous history of related instances.[19]

Consider what we know about our patient at this point. She is female and at higher risk for abuse. While she does not have a disease causing physical limitations, her income is inadequate to permit her independence. She enters the emergency room with obvious physical trauma that would be difficult to explain from a simple fall. There is a history of multiple related incidents that increase our suspicion of elder abuse.

While it may not be necessary to understand the dynamics of abuse in order to intervene and report this case to Adult Protection Services, a determination of its etiology may help the abuser as well as the abused and establish the best possible course of posthospital therapy. The etiology and dynamics of elder abuse have been reviewed in several publications.[20–24] The several theories emphasize the physical dependence of the patient, violence as a learned behavior, and the individual problems of the abuser. O'Malley et al[20] entitled these respectively as (1) the physically dependent elderly person, (2) the stressed caretaker, (3) the violent family, and (4) the pathologic abuser.

Several researchers conclude that the physically dependent elder's inability to perform activities of daily living leads to dependency and subsequent vulnerability to abuse by a caretaker.[15,25] Their dependency becomes a source of stress. The elderly person may not only be a source of stress because of unrelenting demands for care, but may also be a financial burden.[20] External stresses on the caretaker such as loss of job, personal illness,[15] low income, and employment problems[26] also contribute to domestic violence. In some families stress leads to violence, which becomes a way of life.[20] (Transgenerational violence may occur with abuse of child, spouse, and elderly parents.) Finally, there are "nonnormal caregivers" who are retarded, schizophrenic, sociopathic, or otherwise impaired.[18] In these pathologic abusers, drug and alcohol abuse, as well as sociopathic behavior, is felt to result in domestic violence.[20]

In our present case, Mrs. C. is an actual source of income to her family through her food stamps and Social Security benefits. Mr. B. has lost his job and has a history of sociopathic behavior. While Mrs. C. has no chronic disability, she does take up space, and there are five children in this small home. The patient's profile, physical examination, and family dynamics are consistent with elder abuse (both physically and fiscally) and intervention is indicated.

FIRST-YEAR RESIDENT: Adult Protective Services was mentioned as part of the social history. What are these services?

MS. SHEPHARD: APS is an agency within the Suffolk County Department of Social Services that is charged with providing a system of preventive, supportive, and surrogate services for the elderly living in the community. The

continued on page 586

continued from page 584

agency provides a wide variety of health, housing, and social services such as homemakers, house repair, friendly visitors, and meals. Coordination for these services is provided by a caseworker who is responsible for assessing an individual's needs. Suspected abuse or neglect should be reported to APS, whose case workers will go into the home to investigate. They can continue contact and provide services (eg, helping the elderly person relocate or file assault charges), however, only if they have the consent of the patient. In our case presentation, abuse is strongly suspected but denied by the abused.

SECOND-YEAR RESIDENT: Is this denial unusual on the part of the abused? What is the physician's role in all of this?

DR. TRILLING: O'Malley and colleagues[20] discuss the "right to be abused." Legally, the patient may decide to do nothing to change the situation. The physician has an obligation to ensure that the patient has made that decision without coercion and with competency. A survey reports that 40 percent of abused elderly patients refuse evaluation.[15]

Kimsey et al[3] address the question of why so many of the elderly remain silent in the face of abuse. They speculate that fear of retaliation by the formal caretaker is the greatest cause. A second possible explanation is ignorance of their rights and legal recourse. A third possibility is apathy secondary to a sense of inevitability of impending death that enhances a sense of helpless and depression. Whatever its cause, the victim frequently denies abuse,[14] as in the case of Mrs. C.

SECOND-YEAR RESIDENT: One wonders why other family members did not intervene on Mrs. C's. behalf. Why was her daughter so difficult to interview?

DR. TRILLING: Burstone[27] reports that some families adopt a defensive posture, denying problems with an elderly parent in order to maintain "family homeostasis." Additionally, child or spouse abuse has not been ruled out in this family, and they may fear for their own safety. The complexity of this family's interactional dynamics may not be fully appreciated until after long-term supportive relationships and observation.

In organizing an approach to intervention in elder abuse, O'Malley et al[20] suggest dividing cases into two broad categories: those in which the abused has physical or mental impairments and is dependent on the family for daily care needs, and those in which care needs are minimal (as in this case) but are overshadowed by the pathologic behavior of the caretaker. In the first instance, if the elder's needs can be met by other sources, (ie, nursing home, other friends or relatives) and the victim wants a separation, you can obtain a court order to vacate. If the elder does not desire separation, one must try to modify the abuser's behavior. Mrs. C. represented the second category. Her care needs were minimal, and if she had expressed a desire for separation, alternative housing could easily be arranged. Because she was reluctant to be separated from her family, we explored modifying the abuser's behavior. After interviewing Mr. B., we felt that modification of his behavior was futile. Counseling and job training were declined.

Our next approach was to provide support services for Mrs. C. to minimize opportunity for abuse. Mrs. C. was referred by us to a senior center, where she could associate with people her own age on weekdays. It was our hope that by attending this center, she would be away from her son-in-law a good deal of the time. Additionally, it was hoped she would make friends and develop a relationship strong enough to permit her to ask for help. After one month at this center in the face of continued abuse at home, the patient finally admitted (to newly made friends) that her son-in-law was abusing her.

APS was notified, and Mrs. C. agreed to be moved to an Adult Home. (This is not a nursing home, but a self-care living facility). No criminal charges could be brought against Mr. B. because Mrs. C. would not file a criminal complaint. APS did investigate the possibility of child abuse in the same family. They would not share that information with us. If they were to find evidence of abuse, Child Protection Services (CPS) would then be notified. These organizations are not federal, but are local government agencies. Every state has such agencies that are easily contacted through hospital social service departments.

In conclusion, we need to be aware of the predisposing factors in elder abuse to prevent and diagnose this problem. Knowledge of the typical patient profile and family dynamics of elder abuse is needed. Legally mandated separation of the elderly person and the abuser can be attempted, but the elderly person's right to refuse any intervention must be recognized. Provision of support services is an important therapeutic modality when alternative living arrangements are refused by the patient. Availability of these services varies among communities, but generally include home health aides, homemakers, transportation, elder centers, medical nursing care, counseling, and respite care. For further discussion regarding utilization by physicians of support services for elderly patients, the article by Yeo and McGann[28] should be consulted.

Because the family is such an important factor in older people's lives, families come to us for advice. While the majority of families may be ready to assist older relatives, it is quite possible they have not delineated all the inherent problems. Beware of routinely advocating that the family assume a greater role in caring for the aged without assessing the major resultant shift in family functional equilibrium. Inquire about the historical patterns of relationships among the generations. Evaluate the financial and structural resources. Elderly people manifest a broad range of self-care abilities, and the effects of stress imposed on

the caretakers should be discussed openly and at length. By initiating such discussions, we as family physicians may offer the best treatment of elder abuse—prevention.

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