Elder Abuse:

Is Every Bruise a Sign of Abuse?

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Abstract

Each year, between 1 1/2 and 2 million older adults in the United States are abused. Physicians are in an ideal position to recognize, manage and prevent elder mistreatment. This article uses a problem-solving format to discuss a case report. This case, which spanned two years, highlights the true difficulty in recognizing and managing elder mistreatment.

Key Words: Abuse, neglect, mistreatment, aging, frailty, elderly, elder abuse.

Introduction

THE ELDERLY are the fastest growing segment of the population in the United States (1). Consequently, mistreatment of the elderly is an escalating problem. In fact, it is estimated that each year, between 1 1/2 and 2 million older adults are abused (2). Physicians are in an ideal position to recognize, manage and help prevent elder mistreatment and neglect. To illustrate this, we present a problem-solving format to discuss a case report. This case, which spanned two years, highlights the true difficulty in recognizing and managing elder mistreatment. The value of a multidisciplinary approach is emphasized, in order to achieve optimal care of these difficult cases.

First Office Visit (8/96)

An 84-year-old Hispanic woman arrives at the outpatient office one hour late for her appointment; she is accompanied by her son and his female friend. They report a history of confusion of two years' duration, a growing bulge in the stomach, tremors, and recent bed wetting. Although the patient reportedly has never previously been to a physician, she is not in any distress and appears to be comfortable and cooperative with staff and family. She is alert and oriented to person and time, but not to place. She has resting hand and lip tremors that stop on intention. She has a large, non-tender protruding abdominal mass with bowel sounds, but it is not completely reducible. She has a shuffling gait. Laboratory studies and electrocardiogram are performed. Both dementia and Parkinson's disease are suspected at this time. The patient is diagnosed as having a ventral hernia. She is given a one-week follow-up appointment to review laboratory results.

Discussion

It is unsettling that an 84-year-old woman with multiple medical complaints has never seen a physician. Clarification of the patient's functional status and social situation, including caregiver information, is needed at this point. Some questions to consider are:

Why is it urgent for the patient to be seen?
Is there a new stressor requiring medical attention?
Has the patient's functional status worsened over days, months, or years?
Is the caregiver qualified to provide all the care?

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This manuscript has been updated as of August 5, 2002.

What is the role of the son's friend?

During the physical examination, one can request that the family step outside, and use this opportunity to interview the patient alone. One can initiate conversation with a routine question such as "How are things at home?" and follow it with more specific questions, such as those listed in Table 1 (3, 4).

TABLE 1
Questions to Elicit Elder Abuse (3, 4)

Physical Abuse:	Are you afraid of anyone at home? Have you been struck, slapped or kicked? Have you been tied down or locked in a room? Has anyone touched you without your permission?
Emotional Abuse:	Do you ever feel alone? Have you been threatened with punishment, deprivation, or institutionalization? Have you received the "silent treatment"? Have you been force fed? What happens when you and your caregiver disagree?
Neglect:	Do you lack aids such as eyeglasses, hearing aids, or false teeth? Have you been left alone for long periods? If you need assistance, how do you obtain it? How do you get help?
Financial abuse:	Does your caregiver depend on you for shelter or financial support? Has money been stolen from you?

Second Office Visit (9/96)

The patient has been having difficulty ambulating since the last visit, and the tremors continue. Laboratory values are within normal limits except for borderline low vitamin levels. Levodopa / carbidopa is initiated for the treatment of Parkinson's disease. Dementia is still suspected, but the etiology is still unclear and requires further evaluation.

The social worker ascertains that the son is partially disabled and unemployed, and depends on his mother for housing and finances. He is able to help her with activities of daily living. The patient expresses concern about her increasing dependency. The social worker initiates a home evaluation.

The home-care team finds that the patient is living in an apartment without heat, electricity, or food, and begins to investigate financial resources and support services for the patient. Adult Protective Services is also notified.

Discussion

A home evaluation can provide a better understanding of the social environment (5). In this case, a home evaluation was initiated by the physician, who consulted with a social worker. The American Medical Association (AMA) has emphasized that physicians "are in an ideal position to recognize, manage, and prevent elder mistreatment" (2). A 1991 report from Congress suggests that 1.5 – 2 million older adults in the United States are abused annually. It is estimated that only 1 of 14 elder mistreatment cases is reported to a public agency (2). A majority of states have mandatory reporting laws that require health-care workers to report suspected abuse of elderly persons to an official state agency, usually Adult Protective Services (6). In many states the "suspicion" of abuse, without any proof, is grounds for reporting, and the physician does not have to prove anything (7). Many states grant immunity to physicians who report their suspicions in good faith, and often the reporter remains anonymous. Moreover, physicians should be aware of a potential liability if cases of domestic violence are not detected, diagnosed or reported (7). The goal in contacting Adult Protective Services is to determine what services might benefit the elderly person living in the community, rather than implicating the potential abuser.

Third Office Visit (10/96)

The physician performs an assessment of the patient's cognitive abilities. She has completed grammar school education in Puerto Rico. The patient scores 19 out of a possible 30 points on a Mini-Mental State Examination (MMSE). Of interest, the sentence the patient wrote, when translated into English, was "I am hungry." The patient's tremors improved with levodopa / carbidopa, which helps to confirm the diagnosis of Parkinson's disease. Parkinson's disease explains increased disability in this patient and may be the cause of cognitive impairment.

Adult Protective Services, in conjunction with Home Care Services, arranges for a home

health aide and Meals on Wheels. Further investigation by the social worker reveals that the patient has lapsed Medicaid benefits. The social worker begins a process of reapplying in an effort to restore Medicaid benefits.

The physician receives a call from the home health aide stating that the son had been picked up in a “drug raid,” but had been released. There were no further legal repercussions from this event, and the son was not charged with any wrongdoing.

Discussion

Patient safety is foremost at this point. Does the patient appreciate the unsafe situation in which she may be living? Does she have decision-making capacity? Clarification of her comprehension of the situation, choices she may have, understanding of risks / benefits, and her wishes are necessary at this point. At this time, the physician believed that the patient had decision-making capacity. The patient stated that she wanted to stay in her home and denied any problems at home.

This patient’s MMSE score suggests cognitive impairment. The MMSE examines six different domains, including orientation, registration (capability of immediate repetition of words or instructions), attention and calculation, recall, language, and constructional ability. In population-based norms, lower median scores on the MMSE were found among adults with 8 years of schooling or less (as is true of our patient), than among those with at least 9 years of schooling (8). Thus, this patient’s low level of education may be a complicating factor in using this test as a screen for cognitive impairment. However, it is likely that she has some dementia, which puts her at increased risk for abuse. Indeed, a high prevalence of dementia exists in abuse and neglect cases involving the elderly (9).

Authors describe four types of elder abuse: physical, emotional, financial, and neglect (Table 2) (3, 4, 10, 11). Yet many authorities prefer to avoid terms such as abuse or neglect, and describe a situation as inadequate care of the elderly or mistreatment of the elderly, which allows for acts of omission and commission (12, 13).

This patient has multiple risk factors for abuse and neglect, including functional and cognitive impairment, which makes her dependent on her son, with whom she shares a home (Table 3) (10, 13). The son, who is the main caregiver to his mother, has a history of disabling head trauma and is possibly using illicit drugs. The patient needs to be informed about the incidence of mistreatment of the elderly and the tendency for it to increase in frequency and severity over time (14), as well as its association with a high risk of death (15). Relief of caregiver stress is one avenue to pursue to protect the patient. Support groups, day-care centers, alternative living arrangements, disability benefits, and help from other family members would also achieve some relief of stress (10). The son needs his own medical and social service evaluation, which may enable him to receive disability benefits and provisions for his support.

TABLE 2
Types of Elder Abuse (3, 4, 10, 11)

Physical Abuse — includes hitting, grabbing, slapping, or causing bodily injury, including sexual abuse.

Emotional Abuse — verbal and nonverbal insults, humiliation, infantilization, and threats (experiencing at least 10 episodes in preceding year).

Financial Abuse — theft (social security checks, pensions), misappropriation of funds, and coercion (changing a will or deed).

Neglect (Passive or Active) — failure of a caregiver to provide basic care to a patient, typically involving assistance with the activities of daily living.

TABLE 3
Risk Factors for Elder Abuse (10, 11)

Risk Factors
Poor health and functional impairment of the elderly
Cognitive impairment of the elderly
Substance abuse or mental illness of the abuser
Dependence of abuser on victim
Shared living arrangement
External factors causing stress
Social isolation
History of violence in a relationship
Web of dependency by either caregiver on elder or elder on caregiver
Lack of support systems

Two Months Later (12/96)

The visiting nurse calls the outpatient office to report bruises on the patient’s arms. On examination, there are old small bruises as well as

new areas of redness surrounding these ecchymoses on both forearms. The patient has lost 4 kilograms since her last visit two months ago, despite receiving "Meals on Wheels." The patient is examined alone by this physician, who speaks the same language, and separately by the social worker, who utilizes a translator who is available at the outpatient practice. In both interviews the patient denies being treated poorly, hit, pushed or physically injured in any way. She states that food is always available. She reassuredly states that her son takes good care of her and that she wants to go home.

The son is interviewed and denies any problems. Despite this, he appears restless, anxious and eager to leave. On questioning, the home health aide states that food is often lacking in the home, as the son eats the meals delivered to the patient. The aide has never witnessed physical abuse.

At this time the medical staff believe the patient's bruises are due to the son physically supporting his mother during ambulation. The staff approaches the patient about other relatives who may be available to assist her and asks about whether she has any interest in living in a nursing home. The patient states that she has other children, but does not know how to contact them. The patient has the capacity to make decisions and refuses to change her living arrangements, despite staff concerns about neglect.

Discussion

Has the situation now escalated from one of neglect to one of physical abuse? It is now necessary to reassess the situation and interview the patient in private, away from the suspected abuser(s), as was done. One should interview caregivers separately and determine if their explanations are similar or possibly discordant (10).

Not every bruise is abuse. Elderly skin may bruise easily. During the physical examination, note the size, shape and location of all injuries (16). Photographing the injuries is helpful for documentation (17). Be suspicious of multiple injuries in various stages of healing (10). Look for alopecia, pressure ulcers, welts, scars, abrasions, burns, lacerations, and fractures (16). This patient not only has fragile skin, but is also at risk for falls and trauma secondary to Parkinson's disease, and requires support to ambulate. The son should be educated on how to adequately support his mother in order to minimize trauma.

The staff may face additional challenges when interacting with the patient and caregiver, due to a language, cultural and/or educational barrier. The limited education of the patient, the head trauma history of the son, and the fact that most of the clinic staff did not speak the same language as the patient provide additional challenges. Cultural differences may further compound the difficulty of the staff in comprehending the patient's choice of remaining in an unstable environment. According to Montoya in "Understanding and Combating Elder Abuse in Hispanic Communities," the most important and powerful institution among Hispanics is *la familia* — the family (18). Family loyalty and sacrifice, interdependence, and privacy are values and rules that have protected, empowered, and sustained Hispanics through good times and bad times.

If, at this point, the patient acknowledges mistreatment and is willing to accept assistance, discuss the options for ensuring safety (16). These include admission to a hospital for the sake of safety; placement in a nursing home, adult home, or assisted-living residence; and a court order of protection. If the patient refuses assistance and has decisional capacity, educate him/her about available support services. Provide emergency contact numbers for abuse hot lines, social services, public legal services and local victim services / agencies. If elder abuse is strongly suspected and the patient lacks decisional capacity, guardianship arrangements should be initiated.

Two Months Later (2/97)

The visiting nurse calls the physician to report new abrasions on the patient's buttocks, and small ecchymoses on the dorsum of the hands, bilaterally. The patient is urgently seen again. A multidisciplinary team meeting is held with the outpatient medical and team staff, a social worker and nurse from the home-care agency, and the Adult Protective Services case worker and supervisor. Transfer of financial management is discussed. Adult Protective Services decides to take over financial management of the patient's funds in order to prevent further neglect. Home aide hours are increased to twenty-four hours, seven days a week, and the patient is enrolled in a day-care program.

The community health-care team remains very anxious and repeatedly reports to this physician all potential evidence of abuse. The home-care nursing supervisor requests that the patient be removed from her home against her will and be hospitalized for safety and eventual placement.

Discussion

To comprehensively evaluate elder abuse, a multidisciplinary approach is vital. Periodic team meetings facilitate the management of these complex patients. The team in this case includes a physician, nurse, nurse-practitioner, office-based social worker, community-based social worker, visiting nurse, and Adult Protective Services case worker and supervisor. It is important to keep the care team objective and unified. Issues of staff anxiety, fear of patient injury and legal ramifications need to be addressed. Heightened emotions can create a division in the team, often pitting outpatient staff against home-care staff.

The staff maintains involvement and provides as much care and safety as are accepted by the patient and family. It is important for a health-care provider to remain accessible to the potential victim, who may reject offers of assistance. Victims frequently fluctuate between stages of denial and acknowledgment of the abusive situation (19). Access can be maintained through more frequent visits to the doctor, as was done in this case, or via telephone monitoring.

In this case, one may continue to question whether the patient has the ability to make the decision to stay home. The outpatient staff, based on the patient's apparent understanding of the choices, risks / benefits and ability to defend her judgment, believed the patient has the capacity to make decisions about her living arrangements. The home care team was not in agreement with this decision. They believed her cognitive impairments were hindering her decisions and that she was unsafe at home. The team became increasingly uncomfortable with being involved in her care. They continued to want to admit her into the hospital, which in their view would be safer than her home.

Family Office Visit (8/97)

Two other children (a son and daughter), previously reported by the patient to be estranged, make a surprise visit to the office and discuss their family situation, fears about their stepbrother (the patient's son) and concerns of his maltreatment of their mother. They suspect illicit drug use by the stepbrother, but have no evidence. They suspect he is using her money to support his behavior, as he has no income himself.

Discussion

Why is this family, who were so passive in the past, now actively concerned? What has changed to make them come to see their mother's physician? One must be concerned about patient confidentiality in dealing with "unknown" family members. Would the patient allow her physician to speak to these family members? At this time, it was important to listen to these family members, but not to breach the patient's confidentiality without obtaining the patient's permission. The family provided information. Their concerns were acknowledged and were to be evaluated.

Eight Months Later (4/98)

The mother and son do not come into the office that winter. Subsequently, they report that, over the past several weeks, ambulating has become progressively more difficult and the tremors have become more severe, despite a neurologist's involvement and adjustments in medication dosage. She is no longer able to participate in discussions due to increased lethargy. The son is unable to care for her. The patient is admitted to the hospital to be evaluated for a change in mental status. She is found to be dehydrated.

During the mother's hospitalization the son's impairments become more evident. He lacks the ability to comprehend the overall situation. He easily becomes angry, blames the medical staff for his mother's situation and repeatedly threatens their physician verbally. Multiple discussions are held with the family members about the patient's condition and disposition. As the patient is now incapable of participating in these discussions, it is decided to discharge her to a nursing home, which is felt to be the safest option. In the nursing home, the patient's mental status improves and she begins to eat more on her own. The family visits her regularly.

Conclusion

This physician and office staff felt great frustration throughout the two-year course of this situation. Every office visit left the medical staff on edge, not quite sure if physical abuse was occurring. Were the injuries due to aging frail skin in a patient with Parkinson's disease, and a concerned caregiver doing his best despite his own impairments? Or were the injuries secondary to physical abuse by a caregiver with drug abuse problems, who possibly grew up with a family history of violence? As every bruise is not caused by abuse, it is very impor-

tant to always think broadly in analyzing each circumstance. In this way one may provide optimal care, avoid false accusations and provide for the safety of the patient.

In this case, initially, there was concern that physical abuse was occurring. However, at each visit the patient denied this, and her injuries could be explained by her medical conditions and impaired function. Despite her denials, the staff acknowledged the risk and potential for abuse to develop. After each office visit, the staff was fearful that the patient was returning to an unsafe situation. The diagnostic challenge never diminished; each complaint and injury required close, frequent and objective evaluation, without at the same time antagonizing the patient or her family. By not openly accusing the son, the staff was able to evaluate the social situation and provide much-needed home services, activate Medicaid benefits, and enroll the patient in a day program, while respecting the patient's wish to stay at home for as long as possible.

Elder neglect, as in this case of a patient's and caregiver's physical and mental inabilities to obtain or provide adequate care, is a deeply complex situation. The reality is that progress can be slow and diagnostic certainty may be lacking. In order to achieve resolution, the staff must be patient and be supportive of each other. And they must be prepared to gather and evaluate the evidence, while maintaining respect for patient autonomy and the family's sensitivities.

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